MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

Child's Name: _____ **Date of Birth:** _____
Managed Care Organization: _____ **Child's Medicaid #:** _____

Ages 3 – 5 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often wet or soil his pants? ☐ Yes ☐ No

Does your child have problems at day care or school? ☐ Yes ☐ No

Do you have any concerns about your child:
- Daydreaming? ☐ Yes ☐ No
- Paying attention? ☐ Yes ☐ No
- Sitting still? ☐ Yes ☐ No

Does your child:
- Refuse to obey? ☐ Yes ☐ No
- Refuse to play with others? ☐ Yes ☐ No

Does your child get tired easily? ☐ Yes ☐ No

Does your child often seem:
- Sad? ☐ Yes ☐ No
- Angry? ☐ Yes ☐ No
- Nervous or afraid? ☐ Yes ☐ No
- Cranky? ☐ Yes ☐ No
- Not interested? ☐ Yes ☐ No

Does your child have trouble sleeping? ☐ Yes ☐ No

Does your child have problems with eating? ☐ Yes ☐ No

Is your child often mean to animals or smaller children? ☐ Yes ☐ No

Is there a history of injuries, accidents? ☐ Yes ☐ No
If yes, please specify: _____

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MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

Page Two

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child? ..... ☐ Yes ☐ No
Moving? ..... ☐ Yes ☐ No
Divorce or separation? ..... ☐ Yes ☐ No
Death of a close relative? ..... ☐ Yes ☐ No
Fired or laid off? ..... ☐ Yes ☐ No
Legal problems? ..... ☐ Yes ☐ No
Others (Please specify): _____

Do you have other parenting concerns? ..... ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____
Child's Address: _____
Child's Phone: _____
Referred to: **MD Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Tuberculosis Risk Assessment: *(Starting at 1 month of age and annually thereafter)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Anemia Screening (Starting at 11 years of age and annually thereafter)	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment:
(2 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment:
(11 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10

1. How would you describe your child's appetite?
   - ☐ Fair
   - ☐ Good
   - ☐ Poor

2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?
   - ☐ Always pleasant
   - ☐ Usually pleasant
   - ☐ Sometimes pleasant
   - ☐ Never pleasant

4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week? (*Check all that apply*)

Grains:

- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:.....

Vegetables

- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables.....

Fruits

- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice
- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/ juice:.....

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: .....

Meal and Meal Alternatives

- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/ deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:.....

Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Soft drinks
- ☐ Pies
- ☐ Other fats and sweets: .....

Source: Bright Future Nutrition at http://www.brightfutures.org/nutrition/pdf/pocket.pdf

6. If your child is 5 years or younger, does he or she eat any of these foods? (*Check all that apply.*)
   - ☐ Hot dogs
   - ☐ Marshmallows
   - ☐ Nuts and seeds
   - ☐ Peanut butter
   - ☐ Popcorn
   - ☐ Pretzels and chips
   - ☐ Raisins
   - ☐ Raw celery or carrots
   - ☐ Hard or chewy candy
   - ☐ Whole grapes

7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?

8. Does your child take a bottle to bed at night or carry a bottle around during the day?
   ☐ Yes ☐ No

9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?

10. Do you have a working stove, oven, and refrigerator where you live?
    ☐ Yes ☐ No

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
    ☐ Yes ☐ No
    If yes, on how many days and for how many minutes or hours per day?.....

13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games:
    ☐ Yes ☐ No
    If yes, how many hours per day?.....

14. Does your family watch television during meals?
    ☐ Yes ☐ No

15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ **Date of Birth:** _____

Managed Care Organization: _____ **Child's Medicaid #:** _____

Ages 6 – 9 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child often seem:
- Distrustful of others? ☐ Yes ☐ No
- Have trouble paying attention? ☐ Yes ☐ No
- Blame others? ☐ Yes ☐ No

Do you have concerns about your child's:
- Eating? ☐ Yes ☐ No
- Sleep? ☐ Yes ☐ No
- Weight? ☐ Yes ☐ No

Does your child often complain of "not feeling well"? ☐ Yes ☐ No

Does your child have problems getting along with:
- Parent(s)? ☐ Yes ☐ No
- Other family members? ☐ Yes ☐ No
- Friends? ☐ Yes ☐ No
- School mates? ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior? ☐ Yes ☐ No
- Grades? ☐ Yes ☐ No
- Not wanting to go to school? ☐ Yes ☐ No

Does your child often seem:
- Sad? ☐ Yes ☐ No
- Angry? ☐ Yes ☐ No
- Nervous or afraid? ☐ Yes ☐ No
- Cranky? ☐ Yes ☐ No
- Not interested? ☐ Yes ☐ No

Does your child often:
- Destroy property? ☐ Yes ☐ No
- Lie? ☐ Yes ☐ No
- Steal? ☐ Yes ☐ No
- Hurt animals or smaller children? ☐ Yes ☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

Page Two

Is there a history of injuries, accidents? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child?..... ☐ Yes ☐ No
Moving?..... ☐ Yes ☐ No
Divorce or separation? ..... ☐ Yes ☐ No
Death of a close relative?..... ☐ Yes ☐ No
Fired or laid off?..... ☐ Yes ☐ No
Legal problems?..... ☐ Yes ☐ No
Others (Please specify): _____

Do you have other parenting concerns?..... ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date

Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____
Child's Address: _____
Child's Phone: _____
Referred to: **Maryland Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Tuberculosis Risk Assessment: *(Starting at 1 month of age and annually thereafter)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Anemia Screening (Starting at 11 years of age and annually thereafter)	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment:
(2 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment:
(11 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10

1. How would you describe your child's appetite?
   - ☐ Fair
   - ☐ Good
   - ☐ Poor

2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?
   - ☐ Always pleasant
   - ☐ Usually pleasant
   - ☐ Sometimes pleasant
   - ☐ Never pleasant

4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week? (*Check all that apply*)

Grains:
- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:.....

Vegetables
- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables.....

Fruits
- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice
- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/ juice:.....

Milk and Milk Products
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: .....

Meal and Meal Alternatives
- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/ deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:.....

Fats and Sweets
- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Soft drinks
- ☐ Pies
- ☐ Other fats and sweets: .....

Source: Bright Future Nutrition at http://www.brightfutures.org/nutrition/pdf/pocket.pdf

6. If your child is 5 years or younger, does he or she eat any of these foods? (*Check all that apply.*)
   - ☐ Hot dogs
   - ☐ Marshmallows
   - ☐ Nuts and seeds
   - ☐ Peanut butter
   - ☐ Popcorn
   - ☐ Pretzels and chips
   - ☐ Raisins
   - ☐ Raw celery or carrots
   - ☐ Hard or chewy candy
   - ☐ Whole grapes

7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?

8. Does your child take a bottle to bed at night or carry a bottle around during the day?
   ☐ Yes ☐ No

9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?

10. Do you have a working stove, oven, and refrigerator where you live?
    ☐ Yes ☐ No

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
    ☐ Yes ☐ No
    If yes, on how many days and for how many minutes or hours per day?.....

13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games:
    ☐ Yes ☐ No
    If yes, how many hours per day?.....

14. Does your family watch television during meals?
    ☐ Yes ☐ No

15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ **Date of Birth:** _____
Managed Care Organization: _____ **Child's Medicaid #:** _____

Ages 13 – 20 years

Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.

Do you have trouble paying attention?	☐ Yes	☐ No
Do you often:		
Feel distrustful of others?	☐ Yes	☐ No
Have strange thoughts?	☐ Yes	☐ No
Hear voices?	☐ Yes	☐ No
Have to do things the same way or keep repeating them?	☐ Yes	☐ No
Do you have problems at school with:		
Behavior?	☐ Yes	☐ No
Grades?	☐ Yes	☐ No
Skipping classes?	☐ Yes	☐ No
Do you worry about your:		
Eating?	☐ Yes	☐ No
Sleep?	☐ Yes	☐ No
Weight?	☐ Yes	☐ No
Do you have trouble making or keeping friends?	☐ Yes	☐ No
Do you often feel:		
Sad?	☐ Yes	☐ No
Angry?	☐ Yes	☐ No
Nervous or afraid?	☐ Yes	☐ No
Have you thought about or done any of the following:		
Destroy property?	☐ Yes	☐ No
Hurt animals?	☐ Yes	☐ No
Set fire?	☐ Yes	☐ No
Listen to music with violent message?	☐ Yes	☐ No
Use alcohol?	☐ Yes	☐ No
Use drugs?	☐ Yes	☐ No
Smoke cigarettes?	☐ Yes	☐ No
Sex without protection?	☐ Yes	☐ No
Suicide attempt?	☐ Yes	☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Page Two

Is there a history of injuries, accidents? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as :

Birth of a child? ..... ☐ Yes ☐ No
Moving? ..... ☐ Yes ☐ No
Divorce or separation? ..... ☐ Yes ☐ No
Death of a close relative? ..... ☐ Yes ☐ No
Fired or laid off? ..... ☐ Yes ☐ No
Legal problems? ..... ☐ Yes ☐ No
Others (Please specify): _____

Do you have other parenting concerns? ..... ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (__ __ __) /__ __ __ /__ __ __ __

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____
Child's Address: _____
Child's Phone: _____
Referred to: **Maryland Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Tuberculosis Risk Assessment: *(Starting at 1 month of age and annually thereafter)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child been exposed to anyone with a case of TB **or** a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Anemia Screening (Starting at 11 years of age and annually thereafter)	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment:
(2 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment:
(11 years through 20 years)

	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

Updated 2016

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

1. Which of these meals or snacks did you eat yesterday?
(*Check all that apply*)
- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner or supper
- ☐ Morning snack
- ☐ Afternoon Snack
- ☐ Evening/late-snack

2. Do you skip breakfast 3 or more times a week?
☐ Yes ☐ No
Do you skip lunch 3 or more times a week?
☐ Yes ☐ No
Do you skip dinner or supper 3 or more times a week?
☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?
☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?
☐ Yes ☐ No

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?
☐ Yes ☐ No

6. Are you on special diet for medical reasons?
☐ Yes ☐ No

7. Are you a vegetarian?
☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?
☐ Yes ☐ No

9. Which of the following did you drink last week?*(Check all that apply)*
- ☐ Tap or bottled water
- ☐ Fitness water
- ☐ Juice
- ☐ Regular soft drinks
- ☐ Diet soft drinks
- ☐ Fruit-flavored drinks
- ☐ Sport drinks
- ☐ Energy drinks
- ☐ Recovery drinks
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk (for example, chocolate, strawberry)
- ☐ Coffee or tea
- ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat last week?
(*Check all that apply*)

Grains:
- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:.....

Vegetables
- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables.....

Fruits
- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice

- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/juice:.....

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: .....

Meal and Meal Alternatives

- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:.....

Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Pies
- ☐ Soft drinks
- ☐ Other fats and sweets: .....

11. Do you have a working stove, oven, and refrigerator where you live?
    ☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
    ☐ Yes ☐ No

13. Are you concerned about your weight?
    ☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?
    ☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
    ☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
    ☐ Yes ☐ No
    If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
    ☐ Yes ☐ No
    If yes, how many hours per day?.....

18. Does the family watch television during meals?
    ☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
    ☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?
    ☐ Yes ☐ No

21. Do you ever use any of the following? *(Check all that apply)*
    - ☐ Alcohol, beer, or wine
    - ☐ Steroids (without a doctor's permission)
    - ☐ Street drugs (marihuana, speed, crack, or heroin)

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 10 – 12 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child have trouble paying attention? ☐ Yes ☐ No

Does your child often seem:
- Distrustful of others? ☐ Yes ☐ No
- To express strange thoughts? ☐ Yes ☐ No
- Blame others? ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior? ☐ Yes ☐ No
- Grades? ☐ Yes ☐ No
- Skipping classes? ☐ Yes ☐ No

Do you have concerns about your child's:
- Eating? ☐ Yes ☐ No
- Sleep? ☐ Yes ☐ No
- Weight? ☐ Yes ☐ No

Does your child often complain of "not feeling well"? ☐ Yes ☐ No

Does your child have trouble making or keeping friends? ☐ Yes ☐ No

Does your child often seem:
- Sad? ☐ Yes ☐ No
- Angry? ☐ Yes ☐ No
- Nervous or afraid? ☐ Yes ☐ No

Does your child show any of these behaviors?
- Destroy property? ☐ Yes ☐ No
- Set fire? ☐ Yes ☐ No
- Lie? ☐ Yes ☐ No
- Steal? ☐ Yes ☐ No
- Listen to music with violent message? ☐ Yes ☐ No
- Hurt animal or smaller children? ☐ Yes ☐ No
- Use alcohol? ☐ Yes ☐ No
- Use drugs? ☐ Yes ☐ No
- Smoke cigarettes? ☐ Yes ☐ No
- Sexually active? ☐ Yes ☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Page Two

Is there a history of injuries, accidents? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there any history of maltreatment or abuse? ..... ☐ Yes ☐ No
If yes, please specify: _____

Is there a recent stress on the family or child such as:

- Birth of a child ..... ☐ Yes ☐ No
- Moving ..... ☐ Yes ☐ No
- Divorce or separation ..... ☐ Yes ☐ No
- Death of a close relative ..... ☐ Yes ☐ No
- Fired or laid off ..... ☐ Yes ☐ No
- Legal problems ..... ☐ Yes ☐ No
- Others (Please specify): _____

Do you have other parenting concerns? ..... ☐ Yes ☐ No
Please specify: _____

Provider: Give details of all **Positive** findings.

_____ _____
Provider's Signature Date
Provider's Phone: (___ ___ ___) /___ ___ ___ /___ ___ ___ ___

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____
Child's Address: _____
Child's Phone: _____
Referred to: **Maryland Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Tuberculosis Risk Assessment: *(Starting at 1 month of age and annually thereafter)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Anemia Screening (Starting at 11 years of age and annually thereafter)	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment: *(2 years through 20 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment: *(11 years through 20 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name:_____ **Birth Date:** _____

1. Which of these meals or snacks did you eat yesterday?
(*Check all that apply*)
- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner or supper
- ☐ Morning snack
- ☐ Afternoon Snack
- ☐ Evening/late-snack

2. Do you skip breakfast 3 or more times a week?
☐ Yes ☐ No
Do you skip lunch 3 or more times a week?
☐ Yes ☐ No
Do you skip dinner or supper 3 or more times a week?
☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?
☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?
☐ Yes ☐ No

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?
☐ Yes ☐ No

6. Are you on special diet for medical reasons?
☐ Yes ☐ No

7. Are you a vegetarian?
☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?
☐ Yes ☐ No

9. Which of the following did you drink last week?*(Check all that apply)*
- ☐ Tap or bottled water
- ☐ Fitness water
- ☐ Juice
- ☐ Regular soft drinks
- ☐ Diet soft drinks
- ☐ Fruit-flavored drinks
- ☐ Sport drinks
- ☐ Energy drinks
- ☐ Recovery drinks
- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk (for example, chocolate, strawberry)
- ☐ Coffee or tea
- ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat last week?
(*Check all that apply*)

Grains:
- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains:.....

Vegetables
- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables.....

Fruits
- ☐ Apples/ juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice

- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/juice:.....

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice cream
- ☐ Yogurt
- ☐ Other milk and milk products: .....

Meal and Meal Alternatives

- ☐ Beef/hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meals
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meal and meat alternatives:.....

Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Pies
- ☐ Soft drinks
- ☐ Other fats and sweets: .....

11. Do you have a working stove, oven, and refrigerator where you live?
    ☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
    ☐ Yes ☐ No

13. Are you concerned about your weight?
    ☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?
    ☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
    ☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
    ☐ Yes ☐ No
    If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
    ☐ Yes ☐ No
    If yes, how many hours per day?.....

18. Does the family watch television during meals?
    ☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
    ☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?
    ☐ Yes ☐ No

21. Do you ever use any of the following? *(Check all that apply)*
    - ☐ Alcohol, beer, or wine
    - ☐ Steroids (without a doctor's permission)
    - ☐ Street drugs (marihuana, speed, crack, or heroin)