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

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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:** _____

Updated 2016

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

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:** _____

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

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- ☐ 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)

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