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

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MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
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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
Maryland Department of Health and Mental Hygiene HealthChoice and
Acute Care Administration, Division of Children's Services

https://mncp.dhmh.maryland.gov/epsdt

2014
Maryland Healthy Kids Program
Preventive Screen Questionnaire

### Lead Risk Assessment:
(For well child visits from 6 months up to 6 years)

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

2. Is anyone in the home being treated or followed for lead poisoning?
   - [ ] Y / [ ] N

3. Are there any current renovations or peeling paint in a home that your child regularly visits?
   - [ ] 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

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

### Tuberculosis Risk Assessment:
(Starting at 1 month of age and annually thereafter)

1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?
   - [ ] 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

3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?
   - [ ] 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

5. Does your child have HIV infection?
   - [ ] Y / [ ] N

### Anemia Screening
(Starting at 11 years of age and annually thereafter)

1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
   - [ ] Y / [ ] N

2. Have you ever been diagnosed with iron deficiency anemia?
   - [ ] Y / [ ] N

3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?
   - [ ] Y / [ ] N

4. (FEMALES ONLY) Does your period last more than 5 days?
   - [ ] Y / [ ] N

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

Patient Name: ____________________________________________________________

Birth Date: __________________________

https://mmcp.dhrh.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)

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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?

2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?

3. Is the child/adolescent overweight (BMI > 85th %)?

4. And is there a personal history of:
   - Smoking?
   - Lack of physical activity?
   - High blood pressure?
   - High cholesterol?
   - Diabetes mellitus?

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

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

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1. Have you had a blood transfusion or are you a Hemophiliac?

2. Have you ever been sexually molested or physically attacked?

3. Have you ever been diagnosed with any sexually transmitted diseases?

4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?

5. If sexually active, have you had unprotected sex, with opposite/same sex?

6. If sexually active, have you had more than one partner?

7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?

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

Patient Name: ________________________________  Birth Date: ________________

https://mncc.dhmr.maryland.gov/epsd/Pages/Home.aspx

Updated 2016
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

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
- Yes    - No

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 (marijuana, speed, crack, or heroin)

09/30/2014
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

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