Healthy Kids

MENTAL HEALTH WELLNESS QUESTIONNAIRE

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

Ages 0 - 2

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 following your movement around the room with his eyes? ☐ Yes ☐ No

Does your child rarely laugh or smile? ☐ Yes ☐ No

Does your child not want to play with family members or other children? ☐ Yes ☐ No

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

Does your child seem nervous or afraid? ☐ Yes ☐ No

Does your child seem late learning to talk? ☐ Yes ☐ No

Does your child have trouble sleeping? ☐ Yes ☐ No

During pregnancy did the mother use:

- Alcohol ☐ Yes ☐ No
- Drugs ☐ Yes ☐ No
- Tobacco ☐ Yes ☐ No

(Continued on back)

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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): _____ ☐ Yes ☐ No

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: _____
Reason for Referral: _____
_____