Maine Child Psychology
322 West Road, Belgrade, ME 04917
Telephone: (207) 221-2631 ◆ Fax: (866) 611-6717
MaineChildPsych.com

Background Information Form

In order to understand your concerns and best serve you and your child, please complete this form thoroughly.

Identifying Information and Referral Concerns

Name of person(s) completing this form:_____

Relationship to child: _____Today's Date: _____

Child's Name:_____ Nickname:_____

Date of Birth: _____/_____/_____ Age: _____ Sex: ❑ Male ❑ Female

Please tell us why your child was referred to us:_____

_____

_____

How can we be most helpful to your child and family?_____

_____

_____

What do you see as your child's personal strengths? What activities does your child do well?_____

_____

_____

List any concerns about your child's behavior (refusal, aggression, tantrums, etc)_____

_____

_____

List any concerns about your child's emotions (fears, worry, sadness, etc)_____

_____

_____

List any stressful experiences or traumatic events that have affected your child or family:_____

_____

_____

List any other concerns you may have about your child:_____

_____

_____

Contact Information

Name of Parent/Guardian:_____ Relationship to child:_____
Is the parent: ❑Single ❑Married ❑Separated ❑Divorced If so, is there shared custody? ❑yes ❑no

Second Parent/Guardian:_____ Relationship to child:_____

Mailing Address:_____

Email address: _____

Telephone #: Home:_____ Work: _____ Mobile: _____ Message:_____

Please circle the best method (email address or telephone number) where we can contact you.

Is this child adopted? ❑yes ❑no If yes, does your child know he or she is adopted? ❑yes ❑no

Insurance

Health Insurance Coverage:_____

Insured Name:_____ ID#:_____ Group #:_____

Mental Health Carrier if different (name and phone number):_____

MaineCare #:_____

Pregnancy, Birth and Early Development

Any maternal illness during pregnancy?_____

_____

Maternal medication use during pregnancy?_____

_____

Maternal tobacco/alcohol/street drug use during pregnancy?_____

_____

Any pregnancy complications?_____

_____

Birth hospital:_____ Mother's Name at birth, if different: _____

Mother's age at pregnancy?_____ Child's birth weight:_____ Gestational age (weeks):_____

Type of delivery: ❑Natural ❑Breech ❑C-Section Apgar scores, if known:_____(1 min)/_____(5 min)

Any problems at birth? _____

_____

Did your child develop normally during the first three years of life? ❑yes ❑no

If no, please describe any concerns or problems with your child's early development or behavior (speech delays, colic, wouldn't cuddle, head banging, etc):_____

_____

_____

Please list the age at which your child was first able to do these tasks. If you are not sure of the age, indicate whether your child mastered these skills "early", "on time", or "late" compared to typically developing children, or "NY" if your child is not yet able to do this task:

Sat alone:_____ Walked without assistance: _____

Spoke first words: _____ Spoke short sentences:_____

Bladder trained during day:_____ Bowel trained:_____

Toilet trained at night:_____ Tied shoe laces:_____

Said alphabet in order:_____ Began to read:_____

Physician & Medical Information

Your child's regular doctor:_____ Phone #:_____

Is the doctor aware of this referral? ❑ Yes ❑ No

Allergies:_____

Does your child have any current medical problems or concerns?_____

_____

Is your child on any medication?_____

_____

Is your child in pain? ❑ Yes ❑ No If yes, please describe:_____

Are your child's immunizations up to date? ❑ Yes ❑ No

Child's hospitalizations, serious illness, injuries, surgeries, procedures or medical problems (not previously listed):

_____

_____

_____

Has your child seen a hearing specialist? ❑yes ❑no, who?_____

Date and results of most recent hearing evaluation, if any:_____

_____

Has your child seen an eye doctor? ❑yes ❑no, who?_____

Date and results of most recent eye examination, if any:_____

_____

Has your child seen a dentist? ❑yes ❑no, who & when?_____

Describe any dental problems:_____

School Information

This year's school/preschool:_____

Last year's school/preschool (if different):_____

List any concerns about your child's learning or development (speech problems, poor learning, etc.)_____

_____

What is your child's attitude toward school?_____

Has this child ever been tested for learning problems? ❑yes ❑no If yes, when? _____

Reason for testing:_____

Results:_____

Describe any special assistance this child has received in school:_____

_____

_____

Behavior problems at school:_____

_____

Family Information

Birth mother's name (if not listed above):_____ Age:_____

Occupation:_____ What was the highest grade completed?_____

Birth father's name (if not listed above):_____ Age:_____

Occupation:_____ What was the highest grade completed?_____

List all the people living in your child's home (Parents, step-parents, partner/fiancé, siblings, relatives, etc.):

First and Last Name	Relationship to child:	Age:

List family supports (for example, extended relatives who provide assistance, religious or community supports):

_____

What do you see as your family's strengths? What activities does your family do well?_____

_____

_____

Please list any first degree relatives (birth parents, child's siblings, grandparents, uncles, aunts, cousins) who have had any of the following problems. Please list the person's relationship to this child (abbreviations: M=mother, F=father, MM=mother's mother, FS=father's sister, B=brother, C=cousin, etc):

Learning Problems:_____

Behavior Problems:_____

Legal Problems/Jail:_____

Drug/Alcohol Problems:_____

Depression/Anxiety:_____

Other Psychological or Psychiatric Problems:_____

Epilepsy/Seizures/Mental Retardation:_____

Medical/Health Problems:_____

DHHS

***If the Department of Health and Human Services is the legal guardian, please complete*:**

DHS Caseworker Name:_____

DHS Address:_____ DHHS Telephone #:_____

Nature of Involvement:_____

_____

Current Services and Supports

Please check and provide the name and contact information for any of the following agencies or providers, and approximate dates of service, if known:

- ❑ Daycare provider: _____
- ❑ Speech & Language Services: _____
- ❑ Occupational or Physical Therapy: _____
- ❑ Counseling/Therapy_____
- ❑ Psychological/Psychiatric Evaluations: _____
- ❑ Learning/Intellectual Evaluations (not previously listed): _____
- ❑ Case Management Services: _____
- ❑ Specialty Medical Services (for example, neurology): _____

_____

- ❑ Other: _____

_____

List any other services that your child has received that may not have been mentioned previously:_____

_____

Please use this space to include any additional information you feel it would be important for us to know about you and your child:

<u>Please complete the authorization on the reverse side</u>

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Authorization to Obtain Protected Healthcare Information

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

I authorize **Maine Child Psychology** to **obtain copies** of all medical, social, psychological, academic, and other records from providers that **may include but are not limited to** primary care physicians, medical and psychiatric hospitals, birth hospital, case management agencies, Child Development Services, public and private schools, preschools and child care programs, mental health agencies and individual mental health treatment providers and evaluators. Specific agencies or individuals include: ***[Parent or guardian: list specific agencies or provider names, addresses, and dates of service if known]***

Agency/Individual Name	Address	Dates of Service (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Records to be released **may include but are not limited** to inpatient and outpatient hospital or medical center records; history and physical examinations; admission notes; birth records; discharge summaries; medication listings; office notes; educational, developmental and academic testing; psychological, psychiatric, psychosocial, and mental health evaluation and treatment records (including initial assessments, progress notes, treatment plans and discharge summaries); and alcohol or substance abuse evaluation and treatment records

The authorization is valid for records dated from this child's date of birth through the date this authorization is signed.

This information is being requested for this child's evaluation, treatment, and follow-up care.

State and Federal laws require my specific consent to disclose information pertaining to **mental health and substance abuse evaluation and treatment** information. I understand that I may request to review any information in my medical record, and may refuse to disclose some or all of my records. I understand that such refusal may result in improper diagnosis or treatment, denial of insurance benefits, or other adverse effects. ***[Parent or legal guardian: please check the boxes below indicating your understanding and agreement]***

- ❑ I authorize disclosure of information related to treatment or diagnosis or a psychiatric illness/mental health facility information.
- ❑ I authorize disclosure of information related to treatment or diagnosis of drug/alcohol abuse.

I understand that:

- ♦ I can revoke my consent at any time prior to the release of records by delivering a written and dated notice of my wishes to Maine Child Psychology or the agency releasing these records.
- ♦ I can refuse to disclose some or all of my records. ***[Note to parent or legal guardian: please write in or cross out any agencies or specific records or types of records listed on this authorization form that you do not want released.]***
- ♦ Persons having legal parental or guardian rights for this child may obtain a copy of evaluation or treatment records without my written consent.
- ♦ I may have a copy of this authorization to release protected healthcare information form upon request.

By signing this authorization to release protected healthcare information form, I also understand and authorize **Maine Child Psychology** to:

- ♦ Notify the individual or agency that referred this child for services and my child's primary care provider/physician of the status of the referral and any appointments, including notification if I choose not to schedule an appointment or fail to keep a scheduled appointment.
- ♦ Leave a telephone or email message at the telephone number(s) or email address(es) I provide, informing me of scheduled appointments and services.

My consent to obtain records is effective for 12 months from the date this authorization is signed, unless otherwise noted

I understand that my records may contain information pertaining to **mental health treatment and/or substance abuse treatment,** and agree to the release of this information by signing below.

_____	_____	_____
Signature of parent or legally authorized representative	Date of signature	Please print your name here