Maine Child Psychology

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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/Intellectual Disability:_____

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: