|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name | First Name | Middle Name | Age | Sex M/F | Date of Birth |
| Nickname | Height | Weight | Eye Color | Soc. Sec. # | Languages Spoken |
| Adopted? Yes No | Do you receive adoption assistance for youth?Yes No | Adoption Date? | Place of Birth | Hometown | US CitizenYes No |
| Youth’s ethnicity-circle all that apply:Asian Native American Hispanic/Latino Black/African Pacific Islander Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ Caucasian Mixed Race | Religious Preference | If accepted, does the youth wish to practice while receiving services? Yes No | Is youth married?Yes No |
| Maine Care Number (if applicable) |  |
| Name of other Medical Insurance (if applicable) |  |
|  |
| Name of Policy Holder & their date of birth | Relationship to Student | Group Number |
| Policy Number |
| **Student Information****Legal Guardian(s) and Custody Information**Parents are (circle one)married separated divorced | **\*If separated or divorced, submit all legal documents related to custody with application\*** **Please indicate below who has:** |
| Legal Custody | Physical Custody | Sole Custody |
| Legal Guardian(s) Name(s)1. | Relationship to Student1. | Phone Number(s) Home:1. | 2. |
| 2. | 2. |  |  |
| Home Street Address1. |  | Work:1. | Cell:1. |
| 2. |  |  |  |
| 2. | 2. |
| Mailing Address (if different from above)1. |  | Email:1. |
| 2. |  | 2. |
| **\*NOTE- it is presumed that the youth’s legal guardian(s) will make decisions regarding youth unless otherwise specified in writing** |
| **Case Management Agency Name** | Case Manager Assigned | Phone Number(s) Office:  |
|  | Cell: | Fax: |
| Mailing Address City | Zip | Email: |
| Agency will continue to work with youth if they are accepted into the program? Yes No If no, name of agency youth will be referred to for CM services |
| Agency Name Agency Phone # |
|  Name of last school attended**Education** | Current Grade |
| School Address City Zip | Phone:Fax: | Last day youth attended school |
| Circle One: IEP 504 Neither | Effective Date of IEP or 504? | Student’s Exceptionality | If student received Special Ed services, name and phone of Special Ed. Director  |
| Discipline concerns at school: |
|  **Current Placement**  Is youth living at home with legal guardian? Yes No If no, provide more information here  |
| Name of person youth resides with or program name:  |
| Address: City Zip Phone: |

**Family Information (complete address and contact information if not legal guardian)**

**Sibling Information – list all siblings and others who live with your child**

|  |  |  |  |
| --- | --- | --- | --- |
| Father’s Name | Allowed Contact with Youth?Circle One: Yes No Supervised  | Level of Education | Occupation |
| Home Street Address Town State Zip Code |
| Home Telephone | Cell Phone | Work Phone | Email |
|  |  |  |  |
| Mother’s Name | Allowed Contact with Youth?Circle One: Yes No Supervised  | Level of Education | Occupation |
| Home Street Address Town State Zip Code |
| Home Telephone | Cell Phone | Work Phone | Email |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Gender | Relationship | Biological / Adopted |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Legal and Probation Information**

|  |
| --- |
| **Guardian Ad litem Information**  |
| Name  | Phone Office: |
| Address Town State Zip | Email |

|  |  |  |
| --- | --- | --- |
| Is youth currently on probation? Yes No  | Pending court dates? Yes No  | Currently in detention center? Yes No If yes, Detained or Incarcerated (circle one)   |
| Details of past convictions or pending charges: |
| Probation Officer Name:  | Office Phone: Fax:  | Cell:  |
| Address Town State Zip | Email |
| Youth’s Lawyer’s Name:  | Office Phone:  |
| Address Town State Zip | Email |

|  |  |  |
| --- | --- | --- |
| Name | Relationship to youth | Phone  |
| Address Town State Zip | Email |
| Name | Relationship to youth | Phone  |
| Address Town State Zip | Email |

**Professional Consultations - Please list Psychiatrists, Psychologists, Educational Consultants, etc. who work or have worked with your child. Please attach a separate sheet if necessary.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Professional | Location | Dates of Service |
|  Describe type of service rendered and why consultation was needed: |
| Name | Professional | Location | Dates of Service |
| Describe type of service rendered and why consultation was needed: |
| Name | Professional | Location | Dates of Service |
| Describe type of service rendered and why consultation was needed:  |

|  |
| --- |
| In your words, what is your overall perception of your child’s needs? |
| What is your child’s overall perception of their needs and goals? |
| What are your goals and expectations for youth child’s emotional wellbeing? |
| What are your expectations of your child academically? |

**Goals and Expectations**

**. that have worked with your child.**

**Student’s Strengths, Life Skills and Intervention Services Received**

Significant Adults in your child’s life (name(s) and their relationship(s) to your child)

|  |  |  |
| --- | --- | --- |
| Name | Relationship to youth | Phone  |
| Address Town State Zip | Email |
| Name | Relationship to youth | Phone  |
| Address Town State Zip | Email |

|  |
| --- |
| In your words, what are your child’s strengths, positive qualities, accomplishments, and interests? |
| Emergency Contacts**Early Intervention Services****Behavior/Crisis Information**Did your child receive early intervention services for behavioral/ mental health? If yes, please check-off services receive:\_\_\_ Individual Counseling \_\_\_ (HCT) Home & Community Treatment Svs. \_\_\_ (MST-PSB) Multi Systemic Therapy for Problem Sex. Behavior\_\_\_ Family Therapy \_\_\_ (FFT) Functional Family Therapy \_\_\_ (ACT) Assertive Community Treatment\_\_\_ Medication Management \_\_\_ (MST) Multi Systemic Therapy \_\_\_ Residential Treatment Services\_\_\_ Respite Care \_\_\_ Homeless Youth Services  |
|  |
| In your words, what are your child’s behavioral difficulties and /or mood issues and when did these concerns become apparent? |
| Regarding your child’s social, emotional and behavioral difficulties, what are their potential “triggers” that often result in your child having difficulties? |
| How does your child express feelings of anger, sadness, frustration, and disappointment? (Inwardly, outwardly, harmful to self/others, etc.) |
| When your child is in crisis, what actions have you found **help** your child? |
| When your child is in crisis, what actions have you found tend to **make the situation worse**? |
| Please indicate the age of the youth when they reached the milestones listed below. If information is unknown, please note why here:**Developmental information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Sat Up:  | Crawled: | Walked:  | Talked:  | Engaged in Reciprocal Play:  |
|  | Toilet train: | Separation Free of Anxiety; | Able to dress self: | Puberty Onset: |  |
| **Please answer the following questions regarding pregnancy and the applicant’s birth mother:** |
| Pregnancy Duration: | Full Term | Premature | Birth weight: |
| Was this a normal and uncomplicated pregnancy? (circle one) Yes No Unknown |
| Describe any complications with the pregnancy or delivery: |
| Explain if there was a history of drugs, alcohol, tobacco or mental health issues during pregnancy. |
|  |
|

|  |
| --- |
| Was your child ever diagnosed with developmental or physical delays? Yes or No If yes, check-off all services received.\_\_\_ None \_\_\_Psychological Services \_\_\_ Nursing Services\_\_\_ Occupational Therapy \_\_\_ Assistive Technology \_\_\_ Physical Therapy \_\_\_ Medical Service\_\_\_ Audiology or Hearing Svs. \_\_\_ Counseling and Training for the Family\_\_\_ Speech and Language Svs. \_\_\_ Nutrition Services |
| **Out-of-Home Placements - Please list residential programs, hospitals, treatment centers, wilderness programs etc. who have worked with your child. Please attach a separate sheet if necessary.****hild**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Program | Location | Dates of Service |
| Type of placement and why it was needed:  | Discharge (circle one) Planned Unplanned |
| Name | Program | Location | Dates of Service |
| Type of placement and why it was needed:  | Discharge (circle one) Planned Unplanned |
| Name | Program | Location | Dates of Service |
| Type of placement and why it was needed:  | Discharge (circle one) Planned Unplanned |

 |

 |

**Family /Family History**

|  |
| --- |
| Please describe things you feel your family does well: |
| What do you believe your family relationships need? |
| Describe your child’s relationship with siblings, peers and pets: |
| What are your family’s health/nutritional concerns and strengths? |
| What are your family’s financial/housing strengths/needs? |
| Are there significant issues that have affected the ethnic/cultural background of youth/family? |
| Is there a history of substance abuse in the child’s family? Yes No Please describe:  |

Family/Family History Continued

|  |
| --- |
| Is there a history of mental illness in the child’s family? Yes No Please describe: |
| Is there a history of family trauma e.g. divorce, loss of home etc? |
| Is there a history of family legal issues? |

**Diagnoses:**Has your child received a mental health diagnosis? Yes or No (Circle one) If yes, please include most recent diagnosis/diagnoses here:**Hospital Stays:****Please list your child’s psychiatric hospitalizations below**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital Name:** | **Date of Admission:** | **Date of Discharge:** | **Reason for Hospitalization** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Describe traumatic experiences in your child’s life**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Abuse:** | **Yes / No** | **Age** | **Who, when, how long and the outcome** |  |
| Physical |  |  |  |  |
| Emotional |  |  |  |  |
| **Describe traumatic experiences in your child’s life continued** |
| **Type of Abuse:** | **Yes / No** | **Age** | **Who, when, how long and the outcome** |  |
| Sexual |  |  |  |  |
| Neglect |  |  |  |  |
| Exposure to Domestic Violence |  |  |  |  |
| Traumatic events (divorce, illness, death, separation etc.) |  |  |  |  |

  **To the best of your knowledge, has your child experienced or engaged in any of the following?****Behavior/Concerns**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Behavior/Concerns** | **Yes/No** | **Age of Onset/Duration** | **Description** |  |
| Specific fears and anxieties |  |  |  |  |
| Obsessive-compulsive behavior |  |  |  |  |
| Violent behavior |  |  |  |  |
| Sexual acting out |  |  |  |  |
| Exposure to sexually explicit materials/videos |  |  |  |  |
| Sexually Active? |  |  |  |  |
| History of depression |  |  |  |  |
| Self-abusive behavior or self-mutilation |  |  |  |  |
| **Behavior/Concerns Continued** |
|  |
| **Behavior/Concerns** | **Yes/No** | **Age of Onset/Duration** | **Description** |  |
| Bed wetting |  |  |  |  |
| Enuresis (wets self) or Encopresis (soils self) |  |  |  |  |
| Fire starting |  |  |  |  |
| Cruelty towards Animals |  |  |  |  |
| Eating disorder |  |  |  |  |
| Audio or visual hallucinations |  |  |  |  |
| Significant life changes (moves, schools etc.) |  |  |  |  |
| History of eloping |  |  |  |
| Suicidal attempts/threats |  |  |  |
| Homicidal threats or plans |  |  |  |
| Substance use of any kind-including tobacco, alcohol and vaping  |  |  |  |
|  |
|  |

 |

**Behavior/Concerns Continued**

|  |  |  |  |
| --- | --- | --- | --- |
| **Digital Activity** | **YES/NO** | **# of Hours daily**  | **Behaviors/Concerns related to digital activity**  |
| Video Games |  |  |  |
| Online videos |  |  |  |
| Social Media |  |  |  |
| Computer Access |  |  |  |

**Student’s Medical Provider Information**

|  |  |
| --- | --- |
| Name, Address and Phone for child’s primary care provider: | Date of last physical and name of doctor involved: |
| Name, Address and Phone for child’s dentist | Date of last dental exam and name of dentist involved: |
| Name, Address and Phone for child’s eye doctor: | Date of last eye exam: |
| Name, Address of Medical Specialist | Date of last appointment: |
| **Medications**  |
|

|  |
| --- |
| **Does your child require medications during the school day? Yes No (please circle)** |
| Please list all medications that youth is currently taking below |
| **Medication**  | **Dose/Route** | **Frequency** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medication Information**

|  |
| --- |
| Please explain child’s response to medication(s) including medication(s) tried that did not appear to help: |
| Please describe any additional medication concerns you have for your child: |

 |

**Student’s Medical Information**

|  |
| --- |
| Are there any current dental or vision problems? |
| Does your child wear glasses or contacts? Yes or No (circle one) If yes, indicate which and the reason for needing them: |
| Does your child have a medical condition or other safety concerns, including behaviors, which require special care? If so, please explain and give instructions on special care required.  |
| Specific Nutritional Needs? Yes No If yes, list special diets, preferred foods, aversions to textures, etc: |
| Is there any reason(s) your child would not be able to participate in any/all school related activities? Yes No If yes, please explain below. |

**Youth Physical Trauma(s)/Medical Condition(s)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Trauma/Condition** | **Yes/No** | **Age**  | **Explanation** |
| Head Trauma | YesNo |  |  |
| Allergies | YesNo |  |  |
| Has your child been prescribed epinephrine (EpiPen®) to be used in the event of exposure and /or severe allergic reaction to known allergen? | YesNo |  |  |
| Accident(s) | YesNo |  |  |
| Surgeries | YesNo |  |  |
| History of MRSA? | YesNo |  |  |
| Chronic Health Condition(s)/Other | YesNo |  |  |

|  |
| --- |
| **Please indicate by entering his or her age if your child has had any of the following diseases or illnesses:** |
|  | Age |             |  | Age |             |  | Age |
| Anemia (low red blood count)  |  | Epilepsy |  | Pneumonia, Bronchitis |  |
| Arthritis  |  | Frequent Colds |  | Polio |  |
| Bladder or Kidney Infection  |  | German Measles (three days)  |  | Red Measles (ten days) |  |
| Bone Condition |  | Hearing Disorder |  | Rheumatic Fever |  |
| Chicken Pox |  | Heart Disorder |  | Scarlet Fever |  |
| Constipation or Diarrhea |  | Hepatitis A |  | Scoliosis  |  |
| Convulsions or Seizures |  | Hepatitis BHigh Blood Pressure |  | Tuberculosis |  |
| Diabetes |  | Meningitis, Encephalitis |  | Ulcers |  |
| Ear infection |  | Mumps |  | Sexually transmitted infection |  |
| Eczema, Dermatitis |  | Muscle Weakness  |  | Others: |  |

I represent that the above information is correct to the best of my knowledge and belief. Both parents’/guardians’ signatures are required.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Revised 8/2022 MD