|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 Citizen Yes 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 Student  1. | | | | | | Phone Number(s) Home:  1. | | | | | | | | 2. | | | | | |
| 2. | | | | | | 2. | | | | | |  | | | | | | | |  | | | | | |
| Home Street Address  1. | | | | | |  | | | | | | 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 | Yes  No |  |  |
| Allergies | Yes  No |  |  |
| Has your child been prescribed epinephrine (EpiPen®) to be used in the event of exposure and /or severe allergic reaction to known allergen? | Yes  No |  |  |
| Accident(s) | Yes  No |  |  |
| Surgeries | Yes  No |  |  |
| History of MRSA? | Yes  No |  |  |
| Chronic Health Condition(s)/Other | Yes  No |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 B  High 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