Center for Autism and Developmental Disorders Outpatient Clinic
Maine Behavioral Healthcare

Patient Information Questionnaire

Please note that in order to become a patient at our clinic the child must have an established diagnosis of autism spectrum disorder and/or intellectual disability. CADD is a treatment-focused center and we do not administer diagnostic testing.

Date Completed _____ Completed by _____

Who referred you to our clinic?
Name_____
Address_____
Phone #_____

Patient Information

Name_____ DOB_____ Age_____
Patient prefers to be addressed as _____
SSN_____-____-_____ Gender M / F
Home Address_____
Home Phone#_____ Alternative phone #_____
Is it OK to leave a message? □ Yes □ No
Patient's Legal Status: Please check one box below to indicate the legal status of the child
□ Minor with guardian □Adult with guardian □ Independent Adult
Living with_____
Primary Language Spoken_____ Interpreter Needed □ Yes □ No

Guardian Information

Name_____
Relationship to Patient_____
Address_____
Preferred Phone # _____ Alternate Phone #_____
Guardian's email address _____
Primary Language Spoken_____ Interpreter Needed □ Yes □ No

If patient is a minor w/guardian, are there shared parental rights? □ Yes □ No

Co-Guardian (if relevant)

Name_____
Relationship to Patient_____
Address_____
Preferred Phone # _____ Alternate Phone #_____
Primary Language Spoken_____ Interpreter Needed □ Yes □ No

Insurance Information

Primary

Company_____ Policy _____
Phone#_____ Group#_____
Subscriber_____ Subscriber's DOB_____
Subscriber Employer_____

Secondary

Company_____ Policy#:_____
Phone#_____ Group#_____
Subscriber_____ Subscriber's DOB_____
Subscriber Employer_____

☐ I acknowledge that Maine Behavioral Healthcare staff will verify my benefits prior to scheduling an intake appointment.

Please tell us a little about why you are seeking services at our clinic and how you are hoping we can help your child.

_____
_____
_____
_____
_____
_____

Clinical Information

Presenting Problem - Please check all that apply – (Circle your #1)

□ Anxiety □ Tantrums □ Self-Injurious Behavior □ Family Issues
□ Depression □ Grief/Loss □ Aggression □ Regression
□ Mood Dysregulation □ Other: _____

Services You Are Seeking

Please select the services you'd like your child to receive at CADD. Your clinician may make recommendations for additional services based on assessment.

□ Individual Therapy for: □ Child with ASD/ID □ Parent □ Sibling
□ Family Therapy
□ Medication Management (Psychiatry) □ Behavioral Treatment (ABA)
□ Social Skills Group □ Case Management
□ Other _____

Current Providers

Psychiatrist/Med Management (current)_____ Phone#_____
Psychiatrist/Med Management (past)_____ Phone#_____
Pediatrician/Family Physician_____ Phone#_____
Developmental Behavioral Pediatrician_____ Phone#_____
Psychologist_____ Phone#_____
Neurologist_____ Phone#_____
Therapist_____ Phone#_____
In-home agency_____ Phone#_____
Speech Therapist_____ Phone#_____
Occupational Therapist_____ Phone#_____
Case Manager/Agency_____ Phone#_____
Is your child currently receiving HCT services? □ Yes □ No

Current Medications

Please list all medications your child is currently taking. Please include dosage and frequency.

Medication _____ Dose _____
Medication _____ Dose _____
Medication _____ Dose _____
Medication _____ Dose _____

Medical History

Has your child been diagnosed with any of the following? (Please check all that apply.)

		Diagnosed by whom? Diagnosed when?
□	Autism	_____
□	Developmental Disorder	_____
□	Intellectual Disability	_____
□	Anxiety	_____
□	ADHD	_____
□	Mood Disorder	_____
□	Depression	_____
□	OCD	_____
□	PTSD	_____
□	Other (please list)	_____

Are there any precautions or medical issues we should know about? □ Yes □ No
If yes, please explain: _____

Behavioral/Mental Health Concerns

Does your child currently engage in physical aggression? □ Yes □ No
If yes, please describe:_____
Has your child ever required a physical restraint? □ Yes □ No
If yes, please describe:_____
Has your child expressed any homicidal or suicidal ideation: □ Yes □ No
If yes, please describe:_____
Does your child have any history of self-harming behaviors? □ Yes □ No
If yes, please describe:_____
Have there been any recent changes/losses in your child's life at home and/or school?
□ Yes □ No
If yes, please explain:_____
Has your child ever experienced trauma? □ Yes □ No
If yes, please explain:_____
Does your child have difficulty at doctors' appointments? □ Yes □ No
If yes, what has been most helpful? _____

Other Helpful Information

Is your child verbal? □ Yes □ No
If no, please circle what is used: PECS Communication Board Electronic Device ASL

What are some of your child's favorite toys/interests?
_____
_____

Is there anything else you would like us to know about your child?
_____
_____
_____

Along with this completed packet, please provide:

_____ Psychological Testing resulting in a diagnosis of autism spectrum disorder and/or intellectual disability (most recent)
_____ Guardianship documents if patient is an adult with guardian or a child with shared guardianship

For ABA Services ONLY (Behavioral Treatment):

_____ Written MD order for ABA Services from PCP or other medical provider

If you have any concerns regarding getting this information to us or completing this form, please call (207) 661-6725 so that we may assist you.

Please mail, fax, or email this packet and accompanying documents to:
Center for Autism and Developmental Disorders
236 Gannett Drive

South Portland, ME 04106
Fax: (207) 761-0783