Mississippi Center for Advanced Medicine
Child and Adolescent Psychology
Intake Questionnaire

Basic Information	
Legal Name of Person Completing this form:	
Date Completed:	Relationship to Child:
Referred by:	

Child's Identifying Information	
Legal Name of Child:	Preferred Name:
Address:	Child's Cell Phone:
Date of Birth:	Gender:
Race/Ethnicity:	Primary Language:
Marital Status of the Child's Biological or Adoptive Parents:	
If divorced, please describe current custody and visitation arrangements:* **PLEASE PROVIDE A COPY OF SEPARATION/DIVORCE DOCUMENTS PERTAINING TO CUSTODY*	

Family Information	
Full Legal Name of **Parent 1** (Biological/adoptive):	
Address:	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	Work Schedule:
Cell Phone:	Work Phone:
E-mail address:	
Full Legal Name of **Parent 2** (Biological/adoptive):	
Address:	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	Work Schedule:
Cell Phone:	Work Phone:
E-mail address:	
Full Legal Name of **Step-parent/Caregiver 1** (if applicable):	
Address:	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	Work Schedule:
Cell Phone:	Work Phone:
E-mail address:	
Full Legal Name of **Step-parent/Caregiver 2** (if applicable):	
Address:	
DOB:	Highest grade completed:
Occupation:	Place of Employment:
Home Phone:	Work Schedule:
Cell Phone:	Work Phone:
E-mail address:	

Reason for Seeking Treatment
Please list the primary concerns you have about your child:
How long have you had these concerns:
What changes would you like to see as the result of treatment:

Mental Health History
Has your child been given any mental health diagnoses? ☐ Yes ☐ No *If Yes, please list and include when diagnosis was given and who gave diagnosis:*
Has your child had previous therapy/counseling of any kind? ☐ Yes ☐ No *If Yes, Name of Provider:* When: How long: What Concerns were addressed:
Has your child had any evaluations/testing (psychological, educational, speech/language) ☐Yes ☐ No *If Yes, please bring copies of all reports to appointment.*
Has your child taken medication for mental health diagnoses (e.g., AD/HD, mood)? ☐ Yes ☐ No *If Yes, please list:*

Medication	Dosage	Start	Stop	Reason

Has your child ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No *If Yes, please explain and include dates:*
Has your child ever attempted to harm him/herself or others? ☐ Yes ☐ No *If Yes, please explain:*
Has your child ever engaged in self-harm behaviors? ☐ Yes ☐ No *If Yes, please explain:*
Has your child ever been abused or neglected? ☐ None ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect *If Yes, please explain (when, by whom, social services involvement, etc.):*
Has your child used substances: ☐ None ☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Other:

Has your child ever misused or taken more medication than prescribed: ☐ Yes ☐ No
If Yes, please explain:

Has your child used medication that was prescribed for someone else: ☐ Yes ☐ No
If Yes, please explain:

Family Mental Health History

Family history of mental health concerns: ☐ Yes ☐ No (If Yes, provide information below)

Disorder	☐	Relative/s	Sought treatment?
Addiction			
ADHD			
Anxiety			
Bipolar Disorder			
Depression			
Eating Disorder			
Intellectual Disability (Mental Retardation)			
Learning Disability			
Obsessive Compulsive Disorder			
Post-traumatic Stress Disorder			
Schizophrenia			
Suicide (attempt or completion)			
Violence			
Other			

Developmental and Medical History

Was your child adopted: ☐ Yes ☐ No
If Yes, when: Country of Origin:

Pregnancy and Birth

Was pregnancy planned: ☐ Yes ☐ No
Did mother use any of the following during pregnancy: ☐ None ☐ Alcohol ☐ Tobacco
☐ Other Drugs: _____ ☐ Prescribed Medications: _____
Were there any complications during pregnancy: ☐ None ☐ High blood pressure ☐ Diabetes ☐ Stress
☐ Depression ☐ Anxiety ☐ Other: _____

Was the baby full term: ☐ Premature ☐ On-time ☐ Late Delivery at _____ weeks
Type of labor:
Please list any problems with delivery:

Child's weight at birth: _____ Length of stay in hospital: _____
Child's condition at birth:

Temperament and Developmental History

As an infant and toddler did your child have any of the following:

Feeding problems	☐ Yes ☐ No	Difficult to soothe	☐ Yes ☐ No
Excessive crying	☐ Yes ☐ No	Unable to show affection	☐ Yes ☐ No
Unable to develop regular sleep pattern	☐ Yes ☐ No	Easily overstimulated	☐ Yes ☐ No

At what age did your child:
Sit without help: _____ Walk alone: _____
Say 1st words: _____ Speak in simple sentences: _____
Stay dry all day: _____ Stay dry all night: _____
Does your child have accidents during: ☐ None ☐ Day ☐ Night
Has your child received any of the following therapies: ☐ None ☐ Speech ☐ Physical ☐ Occupational

Medical History

Primary Care Doctor: Date of last physical exam:

Please list any past and current medical concerns (e.g., headaches, asthma, diabetes, etc.):

Has your child ever been hospitalized for medical reasons? ☐ Yes ☐ No
If Yes, please explain

Please list any surgeries your child has had:

List any seizures, head injuries, loss of consciousness, concussions, or neurological evaluations:

Please list any allergies (environmental, drug, food) that your child has:

Please list current medications:

Medication	Dosage	Start	Stop	Reason

Lifestyle

Any sleep concerns? ☐ Yes ☐ No Does your child sleep through the night? ☐ Yes ☐ No
Bedtime on school nights: _____ Wake-up on school days: _____
Bedtime on weekends: _____ Wake-up on weekends: _____
Where does your child sleep? _____
Does your child have: ☐ None ☐ Nightmares ☐ Night Terrors ☐ Sleepwalking ☐ Other:

Any concerns about eating habits/diet? ☐ Yes ☐ No
If Yes, please explain:

How many meals per day does your child eat? _____
Does your family eat meals together? ☐ Yes ☐ No
Any recent changes in eating habits? ☐ None ☐ Increase ☐ Decrease
Is your child particular about: ☐ None ☐ Textures ☐ Colors ☐ Other: _____
Any concerns that your child: ☐ None ☐ Eats too little ☐ Eats too much ☐ Vomits after eating
☐ Is very picky about food ☐ Has body image issues

How many hours of exercise does your child average per week? _____

What is his/her exercise of choice?

How many hours does your child spend on electronics per day? _____

What types of electronics does your child have access to?

Do you have any concerns about electronics use? ☐ Yes ☐ No
If Yes, please explain

Do you have any concerns about social media use? ☐ Yes ☐ No
If Yes, please explain

Family Medical History

Please list any family medical history that is important for us to know:

Educational History

Attended preschool: ☐ Yes ☐ No	Attended kindergarten: ☐ Yes ☐ No
Name of Current School:	
Grade:	Primary/Homeroom Teacher:
Typical grades:	How many schools has your child attended?

Has your child repeated or skipped a grade? ☐ Yes ☐ No
If Yes, please explain

Has your child been suspended, expelled, or asked to leave? ☐ Yes ☐ No
If Yes, please explain

Has your child received services through a 504 Plan or Special Education (IEP)? ☐ Yes ☐ No
If Yes, please explain

Favorite subjects:	Hardest subjects:

Has your child ever refused to attend school? ☐ Yes ☐ No
If Yes, please explain

Family and Social History

Has your family moved? ☐ Yes ☐ No
If Yes, please explain

Have there been times where your family did not have a home to live in? ☐ Yes ☐ No
If Yes, please explain

Describe the parenting style/s and types of discipline used in the home:

☐ Yell ☐ Time-out ☐ Ground ☐ Rewards ☐ Sticker Chart ☐ "1-2-3 Magic" ☐ Spank ☐ Other

To what extent do parents/caregivers generally agree on how to discipline your child:
(Never agree) 1 2 3 4 5 (Always agree)

Please list any siblings your child has (full, half, step, adoptive):

Name	Age	Gender	Grade	Relationship to Child	Living with Child

Are there other adults involved in your child's care: ☐ Yes ☐ No
If Yes, please explain

What is your family's religious or spiritual affiliation?

Does your child seek friendships with peers? ☐ Yes ☐ No
Do others seek your child's friendship? ☐ Yes ☐ No
Does your child play with children: ☐ Same age ☐ Older ☐ Younger ☐ Prefers to play alone

What are your child's hobbies?

Please describe your child's strengths and positive qualities:

Please describe your family's strengths and positive qualities:

Risk Assessment

Any current involvement with social services/child protective services? ☐ Yes ☐ No
If Yes, please explain

Any current legal issues for the child or family? ☐ Yes ☐ No
If Yes, please explain:

Has your child witnessed domestic violence? ☐ Yes ☐ No
If Yes, please explain:

Are there firearms in the home? ☐ Yes ☐ No
If Yes, how are they secured:

Do you have any current safety concerns? ☐ Yes ☐ No
If Yes, please explain