



Mississippi Center for Advanced Medicine
 Child and Adolescent Psychology and Psychiatry
 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:	
<i>If divorced*, please describe current custody and visitation arrangements:</i>	
<i>*PLEASE PROVIDE A COPY OF SEPARATION/DIVORCE DOCUMENTS PERTAINING TO CUSTODY</i>	

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 (e.g., ADHD, depression, anxiety)? 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 in an acute inpatient psychiatric unit? 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 (e.g., cutting, burning, hitting)? 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 Vape 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			
Autism			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficult to soothe	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive crying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unable to show affection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unable to develop regular sleep pattern	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily overstimulated	<input type="checkbox"/> Yes <input type="checkbox"/> No

Did your child have any delays in sitting up, walking, speaking, toileting? Yes No
 If yes, please explain any developmental delays: _____

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: _____
 Date of last hearing/vision test: _____ Date of last menstrual period: _____
 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	Date Started	Reason

Family Medical History

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

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 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 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:

Educational History	
Attended preschool: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attended kindergarten: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>	
Has your child been suspended, expelled, or asked to leave? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>	
Has your child received services through a 504 Plan or Special Education (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>	
Favorite subjects:	Hardest subjects:
Has your child ever refused to attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>	

Risk Assessment
Any current or past involvement with social services/child protective services? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>
Any current legal issues for the child or family? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain:</i>
Has your child witnessed domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain:</i>
Are there firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, how are they secured:</i>
Do you have any current safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please explain</i>