Children's of Mississippi | Safe Center

University of Mississippi Medical Center

Pre-visit Questions

Please complete and fax to 601-984-5257 prior to scheduled Children's Safe Center visit.

Patient Name:

Person filling out forms: _____

Basis for visit: *check all that apply*

Please bring all identifying paperwork. Including but not limited to: photo identification, court documents, insurance cards, Medicaid cards, previous medical records relating to case, and photographs.

I am concerned about SEXUAL ABUSE because:

- ☐ Child has sexualized behaviors
- ☐ Child around a known or suspected perpetrator
- ☐ Child has anus or genital injuries
- ☐ Child told me or someone else
- ☐ Child has been interviewed at CAC
- ☐ I or someone else witnessed
- ☐ Suspect said they abused child
- ☐ Child has sexual infection
- ☐ A child in same household has sexual infection
- ☐ Child is pregnant
- ☐ Child has had a "rape kit" collected
- ☐ I am NOT concerned

I am concerned about PHYSICAL ABUSE because:

- ☐ Child told me or someone else
- ☐ Child has been interviewed at CAC
- ☐ Child has injuries
- ☐ Child has seen a doctor or nurse already
- ☐ Child around a known or suspected perpetrator
- ☐ I or someone else witnessed
- ☐ I am NOT concerned

I am concerned about NEGLECT because:

- ☐ Child losing weight or always hungry
- ☐ Child not getting needed medicine or treatment
- ☐ Child is NOT going to school
- ☐ Child

Does ANYONE have any audio, video or pictures that show injuries or abuse to child?

- ☐ Yes, audio
- ☐ Yes, video
- ☐ Yes, photo

Legal Guardian Information:

Legal guardian name: _____

Relationship to child: _____

Date of Birth: _____

Address:_____

Telephone Number: (_____) _____

What is the best time to contact legal guardian regarding appointment and lab findings?

_____

Medical History:

Child's primary care provider (include city where seen):

_____

_____

Child's medical sub-specialists (include specialty and city): _____

_____

When was last medical visit and why?

_____

_____

_____

DIET:

Are there any foods your child CANNOT eat? YES NO

_____

Is child currently fed breast milk (human milk) or infant formula? YES NO

If yes, which? _____

CURRENT MEDICATIONS:

Medication name Dosage What for _____ Prescriber

_____

_____

_____

_____

_____

ALLERGIES:

Please include all food and drug allergies and what reaction occurs

_____

_____

VACCINES:

Are child's vaccines (shots) up to date? YES NO

If no, what is missing? _____

If child is at least 9 years old, has child received the HPV vaccine? YES NO UNK

MEDICAL PROBLEMS:

Include all major past and current problems

_____

_____

_____

_____

FEMALES:

If child has started her menstrual cycle, how old was she for her first cycle? _____

When was child's last menstrual cycle start day? _____

Is child pregnant now? YES NO Child pregnant in past? YES NO

If child will be on their menstrual cycle at the time of their scheduled visit, please inform Children's Safe Center staff by phone 601-815-0157 so appointment can be rescheduled

CHILD'S BIRTH HISTORY:

Was child's pregnancy? PLANNED or SURPRISE

Did family ever consider not having child or giving child up for adoption? YES NO

Where was child born (hospital name and city): _____

Was child born? EARLY or ON TIME or LATE How many weeks: _____

Any problems with pregnancy? _____

How was child delivered? VAGINAL or C-SECTION

If C-section, what was the reason? _____

Did OB have to use FORCEPS or VACUUM to deliver baby? YES NO

Were there any delivery complications? YES NO

CHILD'S BIRTH HISTORY CONTINUED

Birth weight: _____ Birth length: _____

Were there any problems after birth? YES NO

How many total pregnancies (include miscarriages and abortions) for mother? _____

How many living children does mother have? _____

How many miscarriages or abortions has mother had? _____

DEVELOPMENT:

Circle what your child CAN do: holds head up sits scoots crawls pulls to stand

walks runs kicks ball climbs stairs alternating feet peddles tricycle

HOSPITALIZATIONS:

Has child ever been hospitalized overnight since birth? YES NO

If yes, when? What for? Where?

_____

_____

_____

SURGERIES:

Has child had any surgeries (include circumcision)? YES NO

If yes, when? What surgery? Which hospital?

_____

_____

_____

EMERGENCY ROOM VISITS:

Has child ever had to go to the emergency room for an accident? YES NO

If yes, when? What for? Which hospital?

_____

_____

_____

_____

_____

Has child ever injured their genitals (private parts)? YES NO

If yes, explain: _____

_____

_____

FAMILY MEDICAL HISTORY:

Have any of the child's first degree relatives (parents, siblings, grandparents, aunts/uncles, first cousins) been diagnosed with a chronic illness? YES NO

If so, what diseases? Do any diseases run through child's family?

Childhood fractures? Osteogenesis imperfecta? Brittle bone disease?

Midgets/dwarves? Early deafness? Bleeding disorders? Hemophilia? Free bleeding? __

_____

_____

Social History:

Address where child resides: _____

_____

How long has child lived there: _____

Who does child live with:

List everyone who lives in the home at least two days a week

Name **Age** _____ **Relationship to child:**

_____

_____

_____

_____

_____

_____

Does child attend daycare or after school care? YES NO

If yes, what is the name of the facility:_____

_____

What school does child attend? _____ What grade? _____

How is child doing in school? _____

Does child have any learning disabilities? YES NO

Does child smoke? YES NO Does child abuse drugs ? YES NO

Where does child sleep? BASSINET CRIB PLAYPEN TODDLER BED ADULT BED

Does child sleep with anyone else? YES NO _____

Social History continued:

Does child bathe with others? YES NO

Does child use car seat, booster seat or seatbelt when riding in a car ? YES NO

Does child use helmet when riding a bicycle ? YES NO

Does child's home have a pool or lake nearby ? YES NO

Does child's home have smoke detectors ? YES NO

Is there a poison prevention plan in child's home? YES NO

Are there any guns in child's homem? YES NO

Is child exposed to drug abuse? YES NO

is child exposed to cigarette smoke? YES NO

How do you discipline child? *Please describe*.

_____

_____

Has child ever been to counseling? YES NO

Has child ever been physically, sexually or emotionally abused before? YES NO

Children's Safe Center Visit

What does child know about coming to their Children's Safe Center appointment?

_____

_____

How does child feel about coming to the Children's Safe Center? _____

_____

Involved agencies:

Please list all involved agencies and any phone numbers or contact information.

_____

_____

_____

_____

Who is child's CPS social worker? _____

_____

Who is the law enforcement officer? _____

_____

Has child been to a Children's Advocacy Center for an interview? YES NO

If yes, when and where?

_____

_____

Has child had a previous medical exam related to the CURRENT case? YES NO

If yes, when and where? _____

_____

_____

Do you have any questions about the Children's Safe Center visit?

_____

_____

_____

_____

Review of Systems:

Please check all that apply:

General ☐weight changes ☐Genetic or inherited disorder

Eyes ☐Glasses or contacts used ☐Vision loss ☐Blurred vision

Ears, Nose, Mouth and Throat ☐hearing loss ☐Nose bleeds ☐Mouth sores ☐Dental problems

Respiratory ☐Coughing blood ☐Shortness of breath

Cardiovascular ☐heart disease

Gastrointestinal ☐Vomiting ☐Abdominal pain ☐Diarrhea ☐Constipation ☐Blood in stool ☐Daytime soiling

Genitourinary ☐Painful urination ☐Penis/vagina hurt or infected ☐Blood in urine ☐Bedwetting ☐Daytime urinary incontinence ☐Sexually transmitted infection

Musculoskeletal ☐Joint problem ☐Muscle problem ☐Bone problem

Skin ☐Rashes ☐Birth marks ☐Burns ☐Scars ☐Stitches ☐Bruises

Neurological ☐Headache ☐Seizures ☐Dizziness ☐Head trauma ☐Confusion ☐Memory loss ☐Difficulty walking ☐Tremor

Psychiatric ☐Depression ☐Fighting ☐Suicide attempt ☐Psychiatric hospitalization ☐School suspension/expulsion ☐Discipline problem

Hematological ☐Easy bruising/bleeding ☐Hx of transfusions

☐**None of the above apply**

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Individual Social History

*Please complete a **separate** sheet for BOTH PARENTS, ALL CAREGIVERS, and ALL individuals who live in the home(s) with child. Leave blank if answer unknown. Duplicate this sheet as necessary.*

Name of parent, caregiver or household member:

Date of birth: _____ Sex: _____

Marital Status: SINGLE MARRIED/REMARRIED SEPARATED DIVORCED WIDOWED

Highest level of education? _____

Currently working? YES NO

Occupation? _____

Where work? _____

How long at current job? _____

Has this person ever been **abused before** (this includes physical abuse, sexual abuse, domestic violence, neglect) as a child? YES NO as an adult? YES NO

Has this person been involved with state child protection before? YES NO

Was this person accused of abuse or neglect? YES NO

Was this person found to have abused or neglected a child? YES NO

Has this person ever been arrested or accused of a crime? YES NO

What for? _____

Does person use tobacco products? YES NO Does person abuse alcohol? YES NO

Does person abuse drugs? YES NO

Does person have a diagnosed mental illness or history of mental illness? YES NO

2500 North State Street, Jackson, MS 39216