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

<table>
<thead>
<tr>
<th>Patient Name:</th>
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<tbody>
<tr>
<td>Person filling out forms: ____________________________</td>
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</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>I am concerned about SEXUAL ABUSE because:</th>
<th>I am concerned about PHYSICAL ABUSE because:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Child has sexualized behaviors</td>
<td>□ Child told me or someone else</td>
</tr>
<tr>
<td>□ Child around a known or suspected perpetrator</td>
<td>□ Child has been interviewed at CAC</td>
</tr>
<tr>
<td>□ Child has anus or genital injuries</td>
<td>□ Child has injuries</td>
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<tr>
<td>□ Child told me or someone else</td>
<td>□ Child has seen a doctor or nurse already</td>
</tr>
<tr>
<td>□ Child has been interviewed at CAC</td>
<td>□ Child around a known or suspected perpetrator</td>
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<tr>
<td>□ I or someone else witnessed</td>
<td>□ I or someone else witnessed</td>
</tr>
<tr>
<td>□ Suspect said they abused child</td>
<td>□ I am NOT concerned</td>
</tr>
<tr>
<td>□ Child has sexual infection</td>
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<tr>
<td>□ A child in same household has sexual infection</td>
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<tr>
<td>□ Child is pregnant</td>
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<tr>
<td>□ Child has had a “rape kit” collected</td>
<td></td>
</tr>
<tr>
<td>□ I am NOT concerned</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>I am concerned about NEGLECT because:</th>
<th>Does ANYONE have any audio, video or pictures that show injuries or abuse to child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Child losing weight or always hungry</td>
<td>□ Yes, audio</td>
</tr>
<tr>
<td>□ Child not getting needed medicine or treatment</td>
<td>□ Yes, video</td>
</tr>
<tr>
<td>□ Child is NOT going to school</td>
<td>□ Yes, photo</td>
</tr>
<tr>
<td>□ Child does not have a place to live</td>
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</tbody>
</table>
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*
2500 North State Street, Jackson, MS 39216
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: ___________________________

2500 North State Street, Jackson, MS 39216
Pre-visit Questions
University of Mississippi Medical Center

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
2500 North State Street, Jackson, MS 39216
Pre-visit Questions

University of Mississippi Medical Center

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?


________________________________
________________________________

2500 North State Street, Jackson, MS 39216
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

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to child:</th>
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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  _________________________________
Pre-visit Questions

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 home?  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?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Pre-visit Questions

University of Mississippi Medical Center

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
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