RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

Welcome to RBE. In order to most efficiently use your face to face time with your clinician, we ask that you complete this form. This information will enable your clinician to understand and help you. If there are any questions you do not wish to answer, please draw a line through them and initial the item(s).

# Child/Adolescent Intake Form

Client's Name:_____ Clinician's Name: _____

Address: _____ City _____ State _____ Zip _____

Phone (H):_____ Phone (C):_____ Phone (Other):_____

Email:_____@_____

SSN: _____ DOB: _____ AGE: _____ Gender: _____

Parent or Guardian Names: _____

Do parents (or guardians) reside at the above address? If not, please indicate additional address(es):

_____

Ethnicity: ☐ Black, not Hispanic origin ☐ Hispanic ☐ White, not Hispanic origin
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Other: _____

## INSURANCE INFORMATION (MUST BE COMPLETED)

Person responsible for this account: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

Employer: _____ Address: _____

Insurance Plan: _____

ID#: _____ Group #: _____

## EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship to you: _____

I give permission to my clinician or a staff member of Ramesh B. Eluri, MD, PC to contact the person listed above in case of an emergency.

Signature: _____ Date: _____

## MEDICAL CONCERNS

Pediatrician/Primary Care Doctor: _____Phone: _____ Fax: _____

Please note any hospitalizations, serious illnesses, surgeries, or injuries: _____

_____

_____

Please note if there has been a history of loss of consciousness, seizures, head injuries, frequent complaints of headaches, or other symptoms to which medical attention has been given: _____

_____

Chronic Medical Problems: _____

_____

_____

(Please continue to Page 2)

Allergies (including medication allergies): _____

_____

**CURRENT PRESCRIPTION MEDICATION:**

| Medication | Dosage | Date First Prescribed | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____

## PRESENTING PROBLEMS & CONCERNS

Please describe the problem that brought you here today: _____

_____

_____

Please check all of your child's behaviors and symptoms that you consider problematic or that you would like to address:

| | | | |
|---|---|---|---|
| ☐ Distractibility | ☐ Change in appetite | ☐ Visual hallucinations | ☐ Manipulative behavior |
| ☐ Hyperactivity | ☐ Withdrawal from people | ☐ Defiance | ☐ No/few friends |
| ☐ Impulsivity | ☐ Anxiety/worry | ☐ Aggression/fights | ☐ Eating problems |
| ☐ Boredom | ☐ Panic attacks | ☐ Homicidal thoughts | ☐ Sleep problems |
| ☐ Poor Memory/Confusion | ☐ Fear away from home | ☐ Frequent arguments | ☐ Nightmares |
| ☐ Hopelessness | ☐ Social discomfort | ☐ Irritability/anger | ☐ Toileting problems |
| ☐ Sadness/Depression | ☐ Phobias | ☐ Peer/sibling conflict | ☐ Fire setting |
| ☐ Thoughts of death | ☐ Obsessive thoughts | ☐ Stealing | ☐ Work/school problems |
| ☐ Self-harm behaviors | ☐ Compulsive behavior | ☐ Destroys property | ☐ Legal problems |
| ☐ Crying spells | ☐ Racing thoughts | ☐ Running away | ☐ Sexual behavior |
| ☐ Loneliness | ☐ Wide mood swings | ☐ Swearing | ☐ Computer addiction |
| ☐ Low self-worth | ☐ Suspicion/paranoia | ☐ Curfew violations | ☐ Alcohol/drug use |
| ☐ Fatigue | ☐ Hearing voices | ☐ Lying | ☐ Lack of motivation |
| ☐ Recurring, disturbing memories | | ☐ Other: _____ | |

Are your child's problems affecting any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ Handling everyday tasks | ☐ Self-esteem | ☐ Relationships | ☐ Hygiene | ☐ Work/School |
| ☐ Housing | ☐ Legal matters | ☐ Finances | ☐ Health | ☐ Recreational activities |

How long have you been dealing with the above symptoms? _____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself?
If yes, please describe: _____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else?
If yes, please describe: _____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else?
If yes, please describe: _____

What do you wish to accomplish through your treatment at RBE? _____

_____

_____

_____

## FAMILY AND DEVELOPMENTAL HISTORY

Child raised by both parents? ☐Yes ☐ No
Child raised by adults other than parent? _____
Please note the dates of any marital separations, divorces, or remarriages? _____
Describe child care arrangements: _____

Please check if your child has experienced any of the following types of trauma or loss:

| | | | |
|---|---|---|---|
| ☐ Emotional abuse | ☐ Teen pregnancy | ☐ Parent illness | ☐ Placed a child for adoption |
| ☐ Sexual abuse | ☐ Neglect | ☐ Homelessness | ☐ Lived in a foster home |
| ☐ Physical abuse | ☐ Violence in the home | ☐ Financial Problems | ☐ Multiple family moves |
| ☐ Parent substance abuse | ☐ Loss of a loved one | ☐ Crime victim | ☐ Natural disaster |

*If child is adopted, please complete to the best of your ability.*

☐Yes ☐ No Were there any medical problems during the pregnancy or birth of your child? If yes, please describe:

_____

☐Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant? If yes, please describe substances used, quantity and frequency: _____

_____

☐Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____

_____

Aside from yourself, who lives in your home?

| Name | Relation to Yourself | Age | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What are the relationships like between your child and the members of your household? _____

_____

_____

Do you have other family members living in the area? _____

_____

**Family Mental Health Concerns:**
Please check if there is a history of any of the following diagnoses in your family. Please indicate which family member demonstrates the concern.

| | | | |
|---|---|---|---|
| ☐ Hyperactivity | _____ | ☐ Anger/Abusive | _____ |
| ☐ Sexual abused | _____ | ☐ Schizophrenia | _____ |
| ☐ Depression | _____ | ☐ Eating Disorder | _____ |
| ☐ Manic Depression/BiPolar | _____ | ☐ Anxiety | _____ |
| ☐ Suicide | _____ | ☐ Alcohol Abuse | _____ |
| ☐ Panic Attacks | _____ | ☐ Drug Abuse | _____ |
| ☐ Obsessive-Compulsive | _____ | | |

**Optional Question:**
Do you have any cultural or spiritual beliefs that the clinician should be aware of? _____

_____

## SOCIAL & DEVELOPMENTAL HISTORY

Who would you describe as your/your child's supports? _____

What are some of the things that your child enjoys doing? _____

Please list some of your child's personal strengths:

_____

_____

_____

## PREVIOUS MENTAL HEALTH TREATMENT

Has your child previously been involved in mental health treatment? If yes, please describe. _____

Do you feel it was helpful? Why? _____

## SCHOOL HISTORY

Current Grade: _____ School Attending/District: _____

| | | | | |
|---|---|---|---|---|
| This year's grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school grades: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| This year's school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| Past school behavior: | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |

Has your child had any of the following difficulties at school?

| | | | |
|---|---|---|---|
| ☐ Suspension | ☐ Incomplete homework | ☐ Learning problems | ☐ Referrals or detentions |
| ☐ Poor grades | ☐ Teased or picked on | ☐ Speech problems | ☐ Attendance problems |
| ☐ Gang Influences | | | |

☐Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)? _____

☐Yes ☐ No Has your child ever received Special Education services? If yes, please describe service received and reason for services: _____

What does your child's teacher say about him/her (please include strengths and concerns)? _____

☐Yes ☐ No Would you like your clinician to collaborate with school staff? If yes, please provide the following information:

Guidance Counselor: _____ Phone: _____

Teacher Name: _____ Phone: _____