Chris Brubaker, MD, PhD
Comprehensive Psychiatry for All Ages

2825 Eastlake Ave E, Suite 120
Seattle, WA 98102
Phone: (206) 486-4993
Fax: (206) 535-6838

Child & Adolescent Psychiatric Intake Form

CHILD'S INFORMATION: DATE COMPLETED: _____

NAME: _____
First name Middle Initial Last Name

DOB: _____ AGE: _____ GENDER: ☐ Male ☐ Female

RACE/ETHNICITY OF CHILD
☐ Caucasian/White ☐ Japanese ☐ Hispanic
☐ African American/Black ☐ Chinese ☐ Native American ☐ Biracial
☐ Asian ☐ Hawaiian ☐ Vietnamese ☐ Other

Are there any communication barriers for the child or parent/guardian? _____

If so, please explain: _____

Person answering questions: _____

Other persons who assisted in completing this form: _____

Who has current custody/guardianship of child? ☐ Mother ☐ Father ☐ Both Parents ☐ DSHS ☐ Relative ☐ Other

☐ If Relative or Other, please explain: _____

Who is legally authorized to receive information about and make decisions regarding this child's care?

_____
Name Relationship Contact information

If the Legal Guardian is someone other than the parents, please complete following:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

CONTACT INFO: _____ _____ _____
Home Phone Cell Phone Email

RELATIONSHIP TO CHILD: _____

CASE MANAGER/PO: _____ AGENCY: _____ PHONE: _____ ☐ N/A

Comment on history / potential changes in custody: _____

_____

Child's Name: _____

MOTHER/MATERNAL CAREGIVER INFORMATION:

Relationship to child: ☐ BIOLOGICAL ☐ ADOPTIVE ☐ FOSTER ☐ STEP ☐ OTHER _____

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

CONTACT INFO: _____ (Home Phone) _____ (Cell Phone) _____ (Email)

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: _____ YEARS OF EDUCATION/DEGREE: _____

GENERAL HEALTH: _____

OTHER COMMENTS: _____

FATHER/PATERNAL CAREGIVER INFORMATION:

Relationship to child: ☐ BIOLOGICAL ☐ ADOPTIVE ☐ FOSTER ☐ STEP ☐ OTHER _____

NAME: _____ DOB: _____

ADDRESS (if different): _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

CONTACT INFO: _____ (Home Phone) _____ (Cell Phone) _____ (Email)

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: _____ YEARS OF EDUCATION/DEGREE: _____

GENERAL HEALTH: _____

OTHER COMMENTS: _____

CURRENT ADDRESS OF CHILD (If different from above)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

CONTACT INFO: _____ (Home Phone) _____ (Cell Phone) _____ (Email)

STEP MOTHER'S NAME & AGE (if applicable): _____

STEP FATHER'S NAME & AGE (if applicable): _____

Child's Name: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

INSURED'S NAME: _____ INSURED'S DOB: _____

INSURANCE: _____ GROUP ID: _____ ID NUMBER: _____

Who currently lives at home? (List all members of household) Number of people in home: _____

NAME	(M/F)	AGE	RELATIONSHIP

Are there any immediate family members in the military? _____ If so, have they served in combat? _____

In what type of living situation does the child reside:
☐ Family Home ☐ Non-parent Relative ☐ Foster Home ☐ Group Home ☐ Other _____

Has family had multiple moves (3+) in past 12 months? ☐ YES ☐ NO

Has family experienced homelessness in past 12 months? ☐ YES ☐ NO

Is the child at risk for out-of-home placement? ☐ YES ☐ NO IF YES, why: _____

OUT-OF-HOME PLACEMENT HISTORY (If Applicable)

Has child ever been separated from parents or primary caregivers for any significant period of time? ☐ YES ☐ NO

How many out-of-home placements has the child had in the past 12 months? _____

Provide information about the child's age, circumstances of separation, and child's response: _____

Child's Name: _____

REASONS FOR EVALUATION:

What are you concerned about?: _____

What do you hope to get from this evaluation/treatment?: _____

Who referred you to this clinic? _____

Is treatment court-ordered? ☐ YES ☐ NO; IF YES, please provide details: _____

CHILD'S SOCIAL-BEHAVIORAL and PSYCHIATRIC / MENTAL HEALTH HISTORY:

How is your child's overall emotional health? _____

General Functioning: (Please check all that apply)

- ☐ Cheerful/happy mood most of the time
- ☐ Sad or tearful most of the time
- ☐ Feelings of hopelessness
- ☐ Withdrawn behaviors
- ☐ Difficulty thinking
- ☐ Under active/sluggish behavior
- ☐ Intentional self harm
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Nightmares
- ☐ Takes more than an hour to fall asleep
- ☐ Night waking for longer than 30 minutes
- ☐ Hard to wake up in the morning
- ☐ Unable to sleep in own bed through the night
- ☐ Sleepwalking
- ☐ Extreme ups and downs in mood
- ☐ Irritability/anger
- ☐ Distinct periods of nonstop activity
- ☐ Exaggerated view of abilities
- ☐ Fast/rapid speech
- ☐ Feels rested after 3-4 hours sleep/ night
- ☐ Fearless/engaging in reckless activities
- ☐ Fearful of places, situations or people
- ☐ Worries about _____
- ☐ Wetting accidents
- ☐ Soiling Accidents
- ☐ Sexual inappropriate touching of others
- ☐ Sexual play with toys or objects
- ☐ Excessive masturbation
- ☐ Intentional vomiting/purging
- ☐ Difficulty concentrating
- ☐ Conflict with authority figures
- ☐ Stealing
- ☐ Physical cruelty to animals
- ☐ Physical aggression
- ☐ Verbal threats to harm others
- ☐ Threat to kill with intent /plan
- ☐ Lying
- ☐ Extreme conflict with siblings
- ☐ Running away
- ☐ Poor social skills
- ☐ Inability to complete tasks
- ☐ Inability to sustain attention
- ☐ Inability to remain seated
- ☐ Over/ hyperactive behavior
- ☐ Easily distracted
- ☐ Poor self-care/poor hygiene

When did these concerns begin?

How often do these occur?

Child's Name: _____

Does your child have behavior problems at home? (please specify): _____

Does your child have behavior problems at school? (please specify): _____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc)? (please specify): _____

Does the child have any past/ current substance use/abuse? ☐ cigarettes ☐ drugs ☐ alcohol ☐ drugs/alcohol ☐ denies use ☐ remission 90+ days ☐ none; If yes, please describe substances used, amount, and effect on child's performance at home and school:

Has the child engaged in any law breaking behavior? ☐ Yes ☐ No (Provide details about history of arrest, detention, diversion, gang involvement, etc.): _____

Has the child had any history of the following emotional/behavioral problems?:

☐ specific phobias: _____
☐ firesetting: _____
☐ animal mistreatment: _____
☐ enuresis/encopresis (bedwetting, soiling): _____
☐ self-injurious behaviors: _____
☐ other: _____

History of violence/grief and loss:

Has child been exposed to domestic violence? ☐ Yes ☐ No
Has child been a witness to violence or traumatic death? ☐ Yes ☐ No
Has child experienced death of parent/psychological parent? ☐ Yes ☐ No

Child abuse/neglect history:

Has child had history of ☐ physical abuse ☐ sexual abuse ☐ persistent inadequate parenting or neglect?
Has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No; please provide details: _____

Has the abuse history been previously addressed by a professional? ☐ Yes ☐ No; If so, how? _____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

Does your child have as many friends as most other children his/her age? ☐ Yes ☐ No
Does your child have friends come over and play at your house? ☐ Yes ☐ No
Does your child play at the houses of his/her friends? ☐ Yes ☐ No
Has your child had friends stay overnight at your house, or stayed overnight at a friend's house? ☐ Yes ☐ No ☐ Not age appropriate

Has child been persistently harassed or abused by peers? ☐ Yes ☐ No

Child's Name: _____

Please list those qualities about your child that you consider to be strong positive points. _____

_____

_____

Please list those qualities about your child that you consider to be strong negative points. _____

_____

_____

Please list any psychiatric or mental health diagnoses your child has received: ☐ None ☐ Unknown

Diagnosis	Current	Past	Provider name & credentials (MD, ARNP, ND, OT, etc)	Year diagnosed	Does diagnosis seem accurate?	List other family members with this same diagnosis (abbreviations below)

Abbreviations for family: F *for* Father, M *for* Mother, Bro *for* Brother, Sis *for* Sister, G *for* Grand, A *for* Aunt, U *for* Uncle, m *for* maternal side, p *for* paternal side, st *for* step.

(For example, mGF is maternal grandfather, pGM is paternal grandmother, pU is paternal uncle, stBro is stepbrother, etc.)

List all past outpatient psychiatric of mental health services: ☐ None ☐ Unknown

Provider Name, Credentials	Dates of treatment	Services provided	Outcomes	Reason for finishing treatment

List any psychiatric hospitalizations, residential or other inpatient treatments: ☐ None ☐ Unknown

Provider name & credentials (MD, ARNP, ND, RN, OT, etc)	Dates of admission and discharge	Services provided	Outcomes	Reason for finishing treatment

Child's Name:_____

List any medications taken for mental health or psychiatric reasons: ☐ None ☐ Unknown

Current	Past	Name of substance	Condition treated	Prescriber	Dose / Schedule	Response/Side Effects

Has the child been consistently taking medications as prescribed? ☐ Yes ☐ No; if No please provide details: _____

_____

_____

Please list any other persons or agencies who have evaluated your child in the past: ☐ None ☐ Unknown

Type of Service	Service provider / Address	Phone / Fax	Results	Dates
		P: F:		
		P: F:		
		P: F:		
		P: F:		
		P: F:		

Child's Name:_____

BIRTH AND DEVELOPMENTAL HISTORY:

This information should be provided as it relates to the biological parents of the child, if known. If information is sensitive and you would prefer not to write it down, please make a note and tell Dr. Brubaker during your visit.

Was the pregnancy planned? ☐ Yes ☐ No

Any difficulty becoming pregnant? If so, please explain: _____

Was the mother exposed to any of the following: ☐ None

	List specific substances/types	Amount	Month of Pregnancy
Alcohol			
Tobacco			
Other drugs (please specify)			
Medications			
X-rays			
Other (please specify)			

Did the mother experience any of the following during pregnancy? ☐ None

	Describe the problem	Month of pregnancy
Fever		
Flu		
Skin rash		
Spotting / bleeding		
Kidney infections		
Vaginal infections		
Swelling of hands / feet / face		
High blood pressure		
Dizzy spells		
Convulsions		
Headaches		
Blurred vision		
Vomiting		
Other illnesses		

Length of pregnancy:_____weeks Age of mother: _____ Weight gain: _____

Describe labor and/or delivery with this child: ☐ Easy, no problems ☐ Difficult (please explain) _____

_____

☐ Natural (vaginal) ☐ C-section ☐ Forceps; Please explain if needed: _____

Child's Name: _____

Did the baby cry immediately after birth? ☐ Yes ☐ No Apgar scores (if known): _____
Birth statistics: Weight: _____ Length: _____ Head circumference: _____
How soon after the birth did the mother see the baby? _____ Hold the baby? _____
Hospital where the child was born: _____
Duration of mother's hospital stay: _____ Baby's hospital stay: _____
Were there any problems noted by anyone while the baby was still in the hospital? (For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____

Were there any difficulties during the baby's first month of life? (excessive crying, health problems, etc.): _____

Was the infant ☐ bottle or ☐ breast fed? Number of months breast fed: _____
Were there any difficulties with feeding (e.g. recurrent vomiting, "colic", poor suck, low weight gain)? _____

Did parents have trouble adjusting to the new baby? _____

Has your child had any formal developmental testing?: ☐ Yes (provide details below) ☐ No

Has your child had received early intervention services?: ☐ Yes (provide details below) ☐ No

Areas of development	Compare your child's development to other children his/her age (please put an X in the boxes below)			Please comment on areas of strength and needs in your child's development *Please note any delay / deterioration / loss of skills*
	About the same	Slower	Faster	
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				

MILESTONES: *WALKING* _____ months *TALKING* _____ months *TOILET TRAINED* _____months

Child's Name:_____

CHILD'S MEDICAL / PHYSICAL HISTORY:

CHILD'S PRIMARY CARE PHYSICIAN (PCP, PEDIATRICIAN or FAMILY DOCTOR):

NAME: _____ PHONE: _____

ADDRESS: _____

When was your child last seen by a physician: _____

For what reason?_____

Date of and results from last physical examination:_____

Are immunizations up to date? ☐ Yes ☐ No

Current height:_____Current weight:_____Is the child's general physical health good? ☐ Yes ☐ No

Serious and/or chronic illness now (or in past)? _____

Sleep problems (too much/too little/snores/sweats)? _____

Does the child have any of the following impairments/conditions (documented)? ☐ None reported
☐ Unknown ☐ Developmental disability ☐ Visual disability ☐ Deaf ☐ Hard of hearing
☐ Medically compromised ☐ medical/physical disability ☐ Neurological disability ☐ FAS/FAE
☐ Chronic medical/neurological condition which affects psychological functioning ☐ Other:_____
☐ Learning disability (specify type): _____

Does the child have any history of seizures or head injury? ☐ Yes ☐ No (If yes, please specify type, duration, frequency, and date of last EEG): _____

Has the child had any serious injuries, accidents or episodes with loss of consciousness? ☐ Yes ☐ No; If yes, please provide details:

_____

History of medical hospitalizations or surgeries: ☐ None ☐ Unknown

Provider Name(s)	Dates / Duration	Conditions treated	Complications

Current or ongoing use of non-psychiatric medications for physical health: ☐ None ☐ Unknown

Name of medication	Condition treated	Prescriber	Dose / Schedule	Response/Side Effects

Has the child been consistently taking these substances as prescribed? ☐ Yes ☐ No; if no please provide details: _____

_____

Child's Name:_____

Homeopathic, naturopathic, herbal or other substances taken for physical health: ☐ None ☐ Unknown

Current	Past	Name of substance	Condition treated	Prescriber	Dose / Schedule	Response/Side Effects

Has the child been consistently taking these medications as prescribed? ☐ Yes ☐ No; if no please provide details: _____

_____

Medication Allergies (please list medications and allergic responses): _____

_____

_____

Has your child had any of the following (please give details):

☐ Recurrent headaches _____
☐ Recurrent stomach aches _____
☐ Recurrent diarrhea _____
☐ Recurrent vomiting _____
☐ Constipation _____
☐ Vision problems _____
☐ Hearing problems _____
☐ Ear infections _____
☐ Recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____
☐ Allergies _____
☐ Wheezing or asthma _____
☐ Bladder problems _____
☐ Problems with urination _____
☐ Weight loss or gain _____
☐ Skin problems _____
☐ Problems with bones, muscles or joints _____
☐ Tremor, shakes or jitters _____
☐ Tics or other movement problems _____
☐ Wets bed or him/herself _____
☐ Soils bed or him/herself _____
☐ Other _____

Sexual Development (menstruation history, sexual activity, use of contraception, pregnancy history):

_____

_____

Does the child have any history of seizures or head injury? ☐ Yes ☐ No (If yes, please specify type, duration, frequency, and date of last EEG): _____

Nutrition: (Please check all that apply – past or current)

	Past	Current	N/A		Past	Current	N/A		Past	Current	N/A
Increased Appetite	☐	☐	☐	Binge Eating	☐	☐	☐	Other_____	☐	☐	☐
Decreased Appetite	☐	☐	☐	Hoarding	☐	☐	☐				

Is the child currently being seen for any of the above? ☐ Yes ☐ No If yes, please describe_____

Child's Name: _____

Food Allergies (please list foods and reactions): _____

_____

Child has made self throw-up after eating ☐ Yes ☐ No Child does not eat a wide variety of healthy foods ☐ Yes ☐ No

PAIN: Past Current N/A

Chronic Pain: ☐ ☐ ☐ If Yes, please describe: _____

Is child currently being seen for any pain-related condition? ☐ Yes ☐ No If yes, please describe: _____

Child experiences a decrease in ability to function in life due to this pain ☐ Yes ☐ No

SCHOOL:

Current School: _____ ☐Elementary ☐Middle School ☐High School

Grade: _____ Teacher or School Contact Name: _____ School Phone: _____

Favorite Classes: _____ Grades in these classes: _____

Least Favorite Classes: _____ Grades in these classes: _____

Extracurriculars: _____

_____

Past / Present truancy: Yes ☐ No ☐

Expulsions Yes ☐ No ☐ Number of times _____ Dates _____

Suspensions Yes ☐ No ☐ In school ☐ Out of school ☐ Number _____ Dates _____

Asked to leave a daycare/preschool Yes ☐ No ☐ Number of times _____ Dates _____

☐ 504 Plan ☐ Special Education / IEP _____

SOCIAL, PLAY AND RECREATION: Describe the child's social, play and recreational interests: _____

_____

_____

Employment information: ☐ N/A ☐ Full-time Student ☐ Part-time Student ☐ Employed ☐ Other: _____

Name of Employer: _____ Job Title: _____

LEGAL HISTORY:

Has the child been charged with a crime? ☐ Yes ☐ No Is the child on probation? ☐ Yes ☐ No

If yes, please explain: _____

SUBSTANCE USE HISTORY: ☐ NONE

☐ Alcohol ☐ Other substance use _____

Attended alcohol/drug abuse treatment: ☐Yes ☐No Has the child been told that they have an alcohol/drug problem: ☐Yes ☐No

Child's Name:_____

PLACEMENT HISTORY: ☐ N/A

Type: ☐ Resource home ☐ shelter ☐ residential facility ☐ Other: _____

Name of facility:_____ Dates/length of stay: _____

Reason for moving: _____

Type: ☐ Resource home ☐ shelter ☐ residential facility ☐ Other: _____

Name of facility:_____ Dates/length of stay: _____

Reason for moving: _____

Please document additional placements on a separate page

CASE PLAN GOAL ☐ NA ☐ Reintegration ☐ Adoption ☐ Guardianship ☐ Maintenance at Home ☐ OPPLA ☐ Other: _____

CONCURRENT CASE PLAN GOAL ☐ NA ☐ Adoption ☐ Guardianship ☐ OPPLA ☐ Other: _____

Visitation Arrangements:

Are there any custody/visitation arrangements? Please describe, noting any court orders:

_____

_____

FAMILY, CULTURE AND RELIGION:

Describe the child's family, cultural and religious connections.

_____

_____

BEREAVEMENT AND GRIEF:

Has the child experienced grief and or loss? If so, describe how your family is supported socially, spiritually and culturally._____

_____

_____

Child's Name:_____

FAMILY HISTORY

Does anyone in the family have any of the following conditions? Check all that apply, past or present. Please use abbreviations for mother's and father's family members (abbreviations listed below table)

Condition / Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Cardiovascular disease/ sudden death from cardiac reason						
Diabetes						
Mental Retardation						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Panic Attacks						
Schizophrenia						
Bipolar Disorder						
Borderline Personality Disorder						
Other personality disorder(s): _____						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						
School suspension/expulsion						
Special Education						
Birth Defects						
Other: _____						

Abbreviations for family: F *for* Father, M *for* Mother, Bro *for* Brother, Sis *for* Sister, G *for* Grand, A *for* Aunt, U *for* Uncle, m *for* maternal side, p *for* paternal side, st *for* step.
(For example, mGF is maternal grandfather, pGM is paternal grandmother, pU is paternal uncle, stBro is stepbrother, etc.)

Child's Name:_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD?

CONSENT AND AUTHORIZATION

By signing below you are:

- Authorizing Chris Brubaker, MD, PhD to provide the client with mental health services.
- Acknowledging that Chris Brubaker, MD, PhD will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client (or parent or guardian if the client is under 18 years of age).
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE BEGINNING SERVICES)

Signature *X*_____ Date_____

Please print name:_____

Must Be Signed by Client, or by Parent or Guardian if Client is Under 18 Years of Age.

.