Katherine Peppers DNP, CPNP, CPMHS, PLLC
3812 Rocking Robyn Run
Knightdale, North Carolina 27585
919-862-7633 - Phone
kp@katherinepeppers.com
949-437-2099 - Fax

# Child/Adolescent Intake Form

Date:_____

Patient's Name:_____

DOB: _____ Age: _____ Gender: Male Female Questioning (circle one)

Parent/Guardian Name: _____ Relationship:_____

Parent/Guardian Name: _____ Relationship:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Employer: _____

Home Phone: _____ Work: _____ Cell:_____

May we email/text appointment reminders? Yes or No (please circle)

Primary Care Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Referred by: _____

May we thank this provider for the referral? Yes or No (please circle)

Emergency Contact (please provide name of a relative/friend who does not live with you)

Name: _____

Address: _____

Home Phone: _____ Work: _____ Cell:_____

We will only contact this person in an emergent situation if we are unable to reach you. Please provide your initials indicating we may contact this person. Initials _____

What is the reason for your visit today? _____

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PLEASE CHECK ALL THAT APPLY AND CIRCLE THE MAIN PROBLEMS

| Sign/Symptom | Past | Now | Sign/Symptom | Past | Now |
|---|---|---|---|---|---|
| Anxiety | | | Language Delay | | |
| Depression | | | Poor social skills | | |
| Mood Changes | | | Sensory concerns | | |
| Anger/Temper | | | Aggression verbal/physical | | |
| Bed wetting/incontinence | | | Low-self esteem | | |
| Fears | | | Hoarding food | | |
| Obsessions | | | Poor attachment | | |
| Compulsions | | | Sleeping difficulty | | |
| Eating problems | | | Motor or vocal tics | | |
| Victim of bullying | | | Poor eye contact | | |
| Temper Tantrums | | | Self-injurious behaviors/cutting | | |
| Weight loss | | | Suicidal ideation | | |
| Weight gain | | | Hx of sexual abuse | | |
| Developmental delays | | | Hx of physical abuse | | |
| Nightmares | | | Homicidal ideation | | |
| Head Injury/Concussion | | | Audtiory/Visual Hallucinations | | |

**Family History (please check all that apply)**

| Condition | Mother | Father | Grandparent | Siblings | Other |
|---|---|---|---|---|---|
| Depression | | | | | |
| Anxiety | | | | | |
| Panic Attacks | | | | | |
| Obsession/Compulsions | | | | | |
| Tics vocal/motor | | | | | |
| Headaches | | | | | |
| Suicidal thoughts | | | | | |
| Attempted suicide | | | | | |
| Learning disability | | | | | |
| ADHD | | | | | |
| Problems with anger | | | | | |
| Problems with assertiveness | | | | | |
| Opposition of Defiance | | | | | |
| Problems with law | | | | | |
| Schizophrenia/Psychosis | | | | | |
| Nervous breakdown | | | | | |
| Heavy Alcohol Use | | | | | |
| Drug use | | | | | |
| Eating Disorder | | | | | |
| Abuse/Neglect | | | | | |
| Other | | | | | |

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**Social History**

Parent Names: _____

Parent Relationship Status: _____

Child's Siblings/Ages: _____

Others residing in the home: _____

Language(s) spoken in the home: _____

Describe the home environment: _____

How do you discipline your child? _____

Discuss family stressors that may be contributing to your child's difficulties: _____

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Describe your child's personality: _____

Describe your child's favorite activity: _____

Does you child prefer to play alone? _____ with other children _____ in a small group _____

Do you have any self-care concerns for your child? _____

How does your child cope with stress? _____

**Prenatal/Developmental History**

Is you child adopted? _____yes _____ no. If yes, do you have contact with the birth parents?

Length of pregnancy: _____ Prenatal care beginning _____weeks

Medications/OTC/Herbals taken during pregnancy: _____

Birth Weight: _____ Type of delivery: _____

Please explain any complications during delivery: _____

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Was the infant hospitalized for any length of time after birth in the neonatal intensive care? ____

If yes, please explain _____

Any parental substance use during pregnancy: _____

Infant feeding method: _____

Did infant have any feeding/sleeping difficulties? _____

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Did toddler have any toileting difficulties or developmental delays? _____

Did infant/toddler require therapy? _____

Did infant/toddler receive services through Head Start/CDSA? _____

Has your child ever been evaluated by a Developmental Pediatrician or Neuropsychiatrist? ____

If yes, please provide name, address, phone and diagnoses_____

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**Academic History**

Name of school: _____ Current Grade: _____

Describe your child's academic performance: _____

Has your child ever repeated a grade? _____ Yes _____ No Which grade? _____

Academic strengths? _____ Academic Weaknesses? _____

Teacher concerns: _____

Any diagnosed learning disability? _____

Participation in any education resource (IEP, 504 Plan, Gifted): _____

Receiving tutoring? _____

**Medical History**

Medication/Food/Environmental Allergies: _____

Last Well Child Exam: _____. **Please provide copy of completed physical form.**

Provider for last Well Child Exam: _____

Last hearing/vision exam: _____Concerns: _____

Immunization Up-to-Date: _____ Yes _____ No. **Please provide current record.**

**Current Medications (Prescription/OTC/Herbals)**

| Name of Medication | Dosage | Purpose | Prescribing Provider |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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Previous Hospitalizations/Surgeries (Please list dates/reason): _____

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Has your child been diagnosed with any neurological, chronic or debilitating conditions? _____

If yes, please explain: _____

Has your child been diagnosed with any genetic/chromosomal abnormality? _____

If yes, please explain: _____

Has your child been evaluated by a neurologist in the past or under the care of one? _____

If yes, please explain: _____

Name of Neurologist: _____

MRI/CT Scan findings: _____ Diagnosis: _____

Has your child ever sustained a head injury? _____

Does your child have any GI concerns (stomach pain, constipation, diarrhea?) _____

Does you child follow a special diet? (gluten free, etc) _____

Is your child routinely followed by any other specialist or therapist? _____

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Has you child had psycho-educational testing in the past? _____ Yes _____ No

Please explain: _____

Has you child been evaluated by a psychiatrist in the past? _____ Yes _____ No

Please explain: _____

Has you child participated in therapy? _____ Yes _____ No

Please explain: _____

Any history of trauma/abuse? (sexual, physical, neglect, emotionally): _____ Yes _____ No

Please explain: _____

History of psychiatric hospitalization? _____ Yes _____ No

Please explain: _____

History of suicide attempts: _____

Any history of Child Protective Service involvement? _____ Yes _____ No

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Please explain: _____

Any information you would like to include: