



All about the Health of your Child

East
8201 Northwoods Drive
Lincoln, NE 68505

North
3262 Salt Creek Circle
Lincoln, NE 68504

South
3901 Pine Lake Road Suite
210
Lincoln, NE 68516

Crete Clinic
2910 Betten Drive
Crete, NE 68333

WWW.COMPLETECHILDRENSHEALTH.COM

• **PHONE: 402-465-5600 • FAX: 402-327-6074**

Welcome to Psychology Clinic. The Psychology Clinic is a specialty clinic staffed by Pediatric Psychologists, Dr. Davies, Dr. Kosse, and Dr. Frerichs. Services are provided to children, adolescents, and their families for developmental, behavioral, emotional, social, and school problems. Our goal is to collaborate with your child's pediatrician to provide a comprehensive assessment and treatment for a wide range of behavioral and emotional concerns. If you need to reach the clinic, please contact us at 465-5600, option #1, then option #2.

Appointment Information

An initial appointment for the clinic typically takes 60-90 minutes. The child and at least one of his/her parent(s)/legal guardian must attend the first appointment. We will discuss the child's and family's history as well as the presenting concerns. Limits of confidentiality and additional clinic procedures will be discussed at the initial session.

After an initial appointment, additional therapy appointments may be scheduled. Therapy appointments typically last 45 minutes. Shorter sessions may be scheduled as needed. Testing and evaluation sessions, if needed, are also conducted after the initial appointment and will vary in length depending on the circumstance. Appointment times before and after school is available; however, these appointment times fill rather quickly.

Cancellation Policy

We request that you contact us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule the appointment. Fewer than 24 hours notice on 2 or more occasions will require us to discuss alternative plans for your child's behavioral health needs.

Insurance Information

Please bring your insurance card with you to every appointment, and promptly inform us of any changes in your insurance coverage. We expect patients to pay their co-pay at the time of service. If the services will not be covered by your child's insurance plan, then you are responsible for full payment the day of the appointment. While most insurance companies reimburse for mental health or behavioral health services, coverage for mental health benefits is different for each company and plan. It is the patient's responsibility to consult their insurance policy or carrier to determine coverage. We recommend that you contact your insurance carrier and ask specifically about your plan's mental health coverage such as number of sessions allowed, types of therapy permitted, and diagnoses not covered by your plan as well as co-pay amount and deductible for mental health services. The patient (or the patient's parent/legal guardian) is responsible for payment of all fees, whether or not they are covered by insurance. If you have questions about this or would like to talk with the billing department about payment options, please contact Sheri Koozer at (402) 437-0877.

• M. Scott Applegate, M.D., F.A.A.P. • Amy Barger, M.D., F.A.A.P. • Paul Bernhardson, M.D., F.A.A.P. • Kara Biven, M.D. • Bradford Brabec, M.D., F.A.A.P.
• Alissa Clough, M.D., F.A.A.P. • Amy Holst, M.D., F.A.A.P. • Sian Jones-Jobst, M.D., F.A.A.P. • David Meduna, M.D. • Sarah Matthias, M.D., F.A.A.P.
• Akhtar Niazi, M.D., F.A.A.P. • Patrick O'Grady, M.D., F.A.A.P. • Stephen Russell, M.D., F.A.A.P. • Sue Springman, M.D., F.A.A.P.
• Corrie Davies, PH.D. • Stacy Kosse, PH.D. • Lynae Frerichs, PH.D. • Tammi Carstens, PA-C • Jamie Jeffrey, CPNP, IBCLC
• Michelle Lingenfelter, CPNP, IBCLC • Jill Rine, PA-C • Kellie Symonsbergen, PA-C • Linda Tucker, PA-C • Melissa Folsom, MPA, IBCLC, ILCE

LEGAL ISSUES/VICTIM ISSUES

Youth legal involvement? NO YES _____

Other family members legal involvement? NO YES _____

Substance Use/Abuse by patient (12 years old and older)? Circle the one that best describes the patient's use.

Caffeine: daily weekly occasionally once or twice never

Nicotine/Cigarettes: daily weekly occasionally once or twice never

Alcohol: daily weekly occasionally once or twice never

Other drugs (including misuse of medication)

Specify drug (s) _____ daily weekly occasionally once or twice never

SCHOOL INFORMATION

Child attends daycare? NO YES (name of daycare/child care provider) _____

Child attends school? NO YES (grade) _____ (If summer, what grade will child be entering).

School _____ Teacher's Name _____

Child's current grades are: _____ Grades last semester were: _____

Has the patient ever been suspended or expelled? NO YES (when) _____

Has the patient ever been retained in a grade? NO YES (when) _____

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? NO YES (when) _____

Has the patient ever had an IEP, 504 Plan, or other Special Education Services? NO YES
(for example, learning disability, behavioral/emotional disorder class, speech/language services, resource room)

DEVELOPMENTAL INFORMATION (please circle answers)

Were there any problems with pregnancy or delivery? NO YES

Were there any concerns with drug/alcohol use or cigarette use during pregnancy? NO YES

Was the child born prior to 36-40 weeks gestation? NO YES If yes, list gestation at birth: _____

What is your impression of your child's health/development during their first year of life? GOOD FAIR POOR

Note the month in which your child achieved the following activities:

Sat alone _____ Crawled _____ Walked _____ Fed Self _____ Spoke Words _____ Toilet Trained _____

(Normal development: Sit 6-8 months; Crawl 9 mo; Walk 12-18 mo; Feed 10-12 mo; Speak 10 mo; Toilet 24-36 mo)

MEDICAL INFORMATION(please circle answers)

Any problems with the patient's vision? NORMAL ABNORMAL CORRECTED

Any problems with the patient's hearing? NORMAL ABNORMAL CORRECTED

Any problems with the patient's speech? NORMAL ABNORMAL CORRECTED

Any problems with the patient's motor skills? NORMAL ABNORMAL CORRECTED

Circle all conditions in which this child has had or currently has:

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

Other medical conditions/health concerns: _____

Any hospitalizations? NO YES If yes, add dates and explanation _____

Use back page if more room is needed

Any surgeries? NO YES If yes, add dates and explanation _____

Any history of head trauma/injury or loss of consciousness? _____

Current Medications

Medication Name	Dosage	Purpose
_____	_____	_____
_____	_____	_____

MENTAL HEALTH HISTORY

Has the patient ever received medications for behavioral/emotional concerns? NO YES

If yes, list medication, dates, and prescribing doctor _____

Has the patient ever received counseling or psychotherapy for behavioral/emotional concerns? NO YES

If yes describe the concerns, dates, and therapists _____

Has a parent or other family members received medication, counseling, or psychotherapy? NO YES

Has anyone in the patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following problems? (circle all that apply)

- ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) LEARNING PROBLEMS DEPRESSION
 ANXIETY MANIC DEPRESSION / BIPOLAR ALCOHOL / DRUG ABUSE SCHIZOPHRENIA
 OBSESSIVE-COMPULSIVE DISORDER (OCD) NONE OTHER _____

SLEEP INFORMATION

Does your child have a bedtime routine? NO YES

What time does your child typically go to bed? _____

What time does he/she typically fall asleep? _____

What time does he/she wake up in the morning? _____

Does the patient snore loudly? NO YES

Does the patient typically wake up in the middle of the night? NO YES

Does the patient typically take a nap each day? NO YES (how long) _____

BEHAVIORAL HEALTH INFORMATION

Describe the best things about your child? _____

List the clubs/groups and favorite activities of your child: _____

Which of the following *have recently been* or *currently are* problems with your child?

	Never	Some	Often	Always		Never	Some	Often	Always
Won't mind	___	___	___	___	Suicidal thoughts	___	___	___	___
Too active	___	___	___	___	Nervous	___	___	___	___
Anger/Temper	___	___	___	___	Cries a lot	___	___	___	___
Clumsy	___	___	___	___	Harms self	___	___	___	___
Destructive	___	___	___	___	Very Shy	___	___	___	___
Easily upset	___	___	___	___	Clings to parent(s)	___	___	___	___
Toileting problems	___	___	___	___	Nightmares	___	___	___	___
Impulsive	___	___	___	___	Aggressive to others	___	___	___	___

What concerns you most about your child? (please answer on the back of this page if needed) _____

Please provide any other information you would like to discuss during your child's upcoming appointment. (Please answer on back of this page if needed) _____