



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

WWW.COMPLETECHILDRENSHEALTH.COM

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

Welcome to Complete Children's Health Psychology Services!

Our Psychology Clinic is a specialty clinic staffed by Pediatric Psychologists. 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 (402) 465-5600.

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 are 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, you will be 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 (or the patient's parent/legal guardian) 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 our Billing Department at (402) 465-5600

* Any problems/stressors in the family in the last year? (for example, death in the family, move, parental/marital conflict, financial stressors, accidents/traumatic events) _____

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

* 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

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

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

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

* Other medical conditions/health concerns: _____

* Specialists/health care providers that are currently involved with the patient's care (e.g., Allergist, Speech Therapist, etc.) _____

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

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

Any history of head trauma/injury or loss of consciousness? NO YES _____

Current Medications

* Medication Name	* Dosage	* Purpose	* Date Started	* Prescribed By

* Any over the counter medications routinely taken? _____

* Any allergies to medication? _____

MENTAL HEALTH HISTORY

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

If yes:

Medication Name	Dosage	Purpose	Date Started	Prescribed By

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

If yes:

* Provider Name	* Treatment Dates	* Was treatment effective

* 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_____

*Does anyone in the immediate family/household have concerns related to substance abuse? _____

LEGAL ISSUES/VICTIM ISSUES

* Has the patient had any law violations or contact with law enforcement? NO YES _____

* Do parents or other family members have legal violations? NO YES _____

* Has the child experienced neglect, physical or sexual abuse, or witnessed domestic violence? NO YES

* Has Child Protective Services (CPS) ever been involved with the family or patient? 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 (marijuana, cocaine, meth, etc): daily weekly occasionally once or twice never

* Misuse of prescription or over the counter drugs: daily weekly occasionally once or twice never

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) _____

