KU WICHITA PSYCHOLOGY
The University of Kansas

Appointment Dates & Times:

Initial Interview & Testing: _____

Feedback Visit: _____

DATE: _____

PATIENT: _____

FROM: Dr. Kelli L. Netson, Pediatric Neuropsychologist

LOCATION: 8533 East 32nd Street North (See Enclosed Map)

Your child/adolescent currently has appointments scheduled with us as listed above. In order to provide you with the best possible care, we need the following information **DELIVERED TO THE OFFICE PRIOR TO THE FIRST APPOINTMENT VIA MAIL, EMAIL, HAND-DELIVERY OR FAX**. If your paperwork is incomplete, your appointment may need to be rescheduled.

- The intake paperwork enclosed in this packet.
- A complete list of ALL of your child's current and previous medications
- Names of your child's current doctor, therapist, psychiatrist, or other healthcare provider
- A list of all hospital stays for medical or psychiatric purposes
- Any previous testing reports (neuropsychological, psychological, psychoeducational, speech therapy, etc.)
- Dates and locations of any brain MRI or CT scans completed
- Your child's most recent report card and standardized school testing results (if available)
- Your child's current IEP, 504 Plan, or any special education documents available

The first appointment will last several hours. The neuropsychologist will meet individually with parents/guardians for approximately one hour to discuss your concerns about your child's functioning. At the same time, your child will begin working with a technician to complete neuropsychological testing. Many of the tasks they will be asked to do are interactive, like games. Family members and attendants are **not allowed** in the testing room with school-aged children and adolescents. Infants, toddlers, and preschoolers may be accompanied by their parents on a case-by-case basis. Breaks will be provided during testing sessions as needed.

- **Please have your child take all regular medications as he/she normally would on the day of testing.** Bring with you any additional doses he/she might need throughout the day.
- Adequate sleep and a healthy breakfast prior to testing will help your child perform his/her best.
- Please arrive 15 minutes early for the first appointment to complete any additional forms. If you are late, the appointment may need to be rescheduled, and that could mean a 1-2 month delay in the evaluation.
- For all-day appointments, a break is taken from 12-1pm for you and your child to leave the office and eat lunch. Lunch is not available in our office; however, there are several restaurants near the office.
- We do not have childcare available in the office for patients or their siblings – please make other childcare arrangements during this appointment.

PLEASE BRING WITH YOU TO THE FIRST APPOINTMENT:

- Insurance cards and your co-pay amount (check, cash, or credit card)
- Reading glasses and hearing aids if your child normally wears them
- Comfortable clothing, suitable for air-conditioned rooms
- Snacks or drinks for use during testing (there are no vending machines at our office)

The final feedback appointment is scheduled for one hour and is an opportunity to discuss test results and treatment plans with the neuropsychologist. **Your child does not need to attend** this appointment unless you and the neuropsychologist have agreed that he/she should be a part of that discussion.

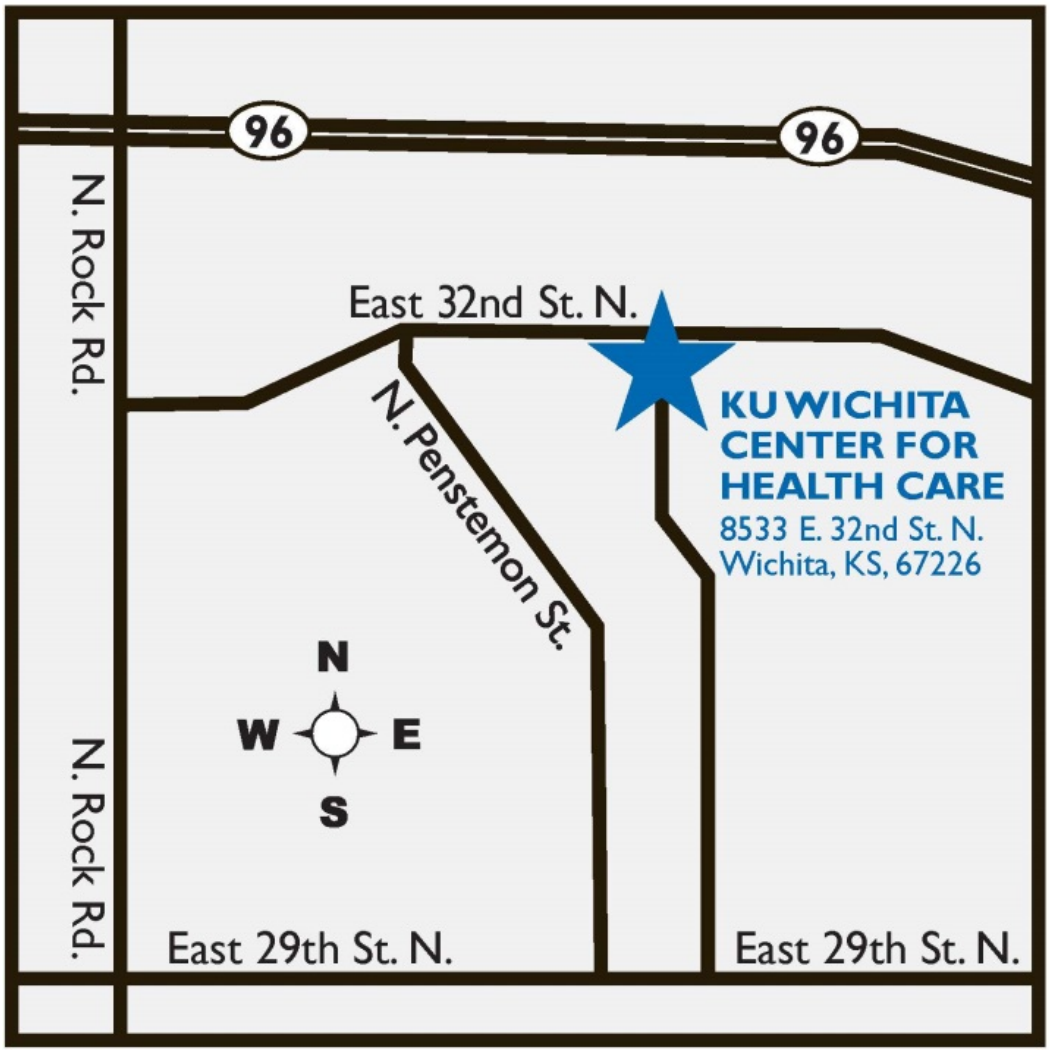
If you have any questions or need further information you may call the office at (316)293-3850, Monday through Friday, 8:00 am to 4:30 pm. You may leave a message at any time. **To reschedule or cancel your appointment(s), please call at least 24 hours in advance.**

Psychology
8533 East 32nd Street North | Wichita, KS 67226 | (316) 293-3850 | Fax (855) 476- 0305

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
The University of Kansas

MAP

KU Wichita Center for Health Care
8533 E 32nd St N in Wichita



KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
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PATIENT INFORMATION

Social Security Number:	Employer:
Name:	Employer Address:
Address:	Employer City:
City:	Employer State: Zip:
State: Zip:	Email:
Home Phone Number:	Referring Provider:
Work Phone Number:	Primary Care Provider:
Cell Phone Number:	Marital Status:
Sex:	Employment: FT / PT / Self / Military / Unemployed / Retired
Date of Birth:	Student Status: FT / PT / Not a student
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Declined	Preferred Language:
Ethnicity: Hispanic or Latino / Refused / Not Hispanic or Latino	Preferred Hospital:

DISCLOSURE

I understand that it is my right to elect to whom my medical, insurance and/or financial information can be released. For our records the first person listed will be your emergency contact. I also understand that if I choose to leave this information blank, the facility will not have an emergency contact or be able to release any information to anyone, including my spouse/significant other, children, parents, siblings, etc. I therefore authorize KUSM-W Medical Practice Associate to release my information as directed below.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

AUTHORIZATION

I do hereby authorize the release of any medical information necessary to process claims on my behalf. I request that all insurance benefits be paid directly to KUSM-W Medical Practice Association for all charges incurred by me. I understand that I am responsible for all charges incurred during my treatment at KUSM-W Medical Practice Association Clinics regardless of insurance coverage. I agree to pay the entire balance of my account in a timely manner.

_____ _____

Responsible Party Signature Date

MPA NOTICE OF PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of the Medical Practice Association's Notice of Privacy Practices

Patient Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Patient received a copy of the MPA Notice of Privacy Practice and refused to acknowledge receipt at this time

Employee Signature: _____ Date: _____

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
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CLINIC POLICIES

Please read the following policies carefully. After reading each policy, initial where shown indicating you understand and agree to our policies.

CONFIDENTIALITY: All communication between you and the clinic is held in strictest confidence and will not be released unless: (1) you authorize release of information with your signature; (2) you present with potential harm to yourself or others; (3) there is suspicion of abuse or neglect of a minor or elder; or (4) the clinic is required to do so by Federal, state or local law. _____ (INITIAL)

EMERGENCIES: In case of emergency, **call 9-1-1** or **go to your nearest emergency room.** For after hour emergencies you may call the Via Christi operator at 316-268-5000. For non-emergency calls you may call the office at 316-293-3850. Leave a message if necessary. Your phone call will be returned within one business day. _____ (INITIAL)

INSURANCE, CO-PAYS, DEDUCTIBLES AND BALANCES: Come to your appointment prepared to make a payment for co-pays, deductibles, balances and charges not covered by your insurance company. We file insurance claims for you as a courtesy. However, unpaid claims due to changes in coverage are your responsibility. **Please call us if your coverage changes between appointments**. _____ (INITIAL)

APPOINTMENTS: Please call the clinic at least 24 hours before your appointment if you need to cancel or reschedule. Three (3) missed appointments within 12 months, inclusive of cancelations less than 24 hours in advance**, may result in dismissal from practice**. _____ (INITIAL)

INCLEMENT WEATHER: In the event of severe weather, please call the clinic before you come. A recording will alert you if we are closed. We will call you the next business day to reschedule your appointment.

TRAINEES: UKSM-W is a teaching facility, therefore psychology interns or fellows, medical students, or resident physicians may be a part of your treatment, supervised by your provider. _____ (INITIAL)

RESEARCH: UKSM-W also works with physicians who are performing a variety of research projects. We may discuss these projects as viable alternatives or additions to your regular care. You may be asked to participate in this research, but you are under no obligation to do so. _____ (INITIAL)

I have read, fully understand and accept responsibility for each item described above.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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CONSENT FOR OUTPATIENT TREATMENT

This document is to obtain your informed consent for evaluation and treatment. Please ask your provider for clarification if you do not fully understand the recommendations.

I hereby consent to a psychiatric evaluation and subsequent treatment, subject to my ongoing involvement in providing consent. I understand that if I wish to accept treatment, I have the right to have the risks and benefits of treatment options explained to me to my satisfaction, including not having any treatment. I understand that I may at any time refuse any intervention in which I do not wish to participate.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Parent or Representative	Signature of Parent or Representative	Date
Printed Name of Clinic Representative	Signature of Clinic Representative	Date

FOR CHILDREN and ADOLESCENTS

Are there custody arrangements, either current or pending, between any parties?

☐ Yes ☐ No

If Yes, please provide additional details: _____

_____

Do any of the following apply to this child/adolescent?

Legal Guardian	☐ No	☐ Yes, Name: _____	Ph: _____
SRS Involvement	☐ No	☐ Yes, Name: _____	Ph: _____
Juvenile Justice Involvement	☐ No	☐ Yes, Name: _____	Ph: _____

PLEASE PROVIDE COPIES OF ANY COURT ORDERS

OR OTHER LEGAL DOCUMENTATION

1001 N. Minneapolis | Wichita, KS 67214-3127 | P. (316) 293-2647 | F. (855) 476-0305

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CHILD & ADOLESCENT HISTORY FORM

Child's Name:_____ **Date of Birth:**_____ **Gender:** ☐ M ☐ F **Race:** _____

Your Name:_____ **Relationship to Child:** _____

Are you the child's legal guardian? YES NO **If not, who has guardianship?**_____

Please list the emotional, behavioral, or learning problems your child is having and specify severity and occurrence.

Problem	Date/Age Started	Severity	How often	Problem occurs at
		Mild Mod Severe	Daily Weekly Rarely	Home School Both
		Mild Mod Severe	Daily Weekly Rarely	Home School Both
		Mild Mod Severe	Daily Weekly Rarely	Home School Both
		Mild Mod Severe	Daily Weekly Rarely	Home School Both

Who referred your child for this evaluation? _____

What kind of treatment would you like to have provided for your child? _____

_____

PSYCHIATRIC TREATMENT HISTORY

Please mark any problems the child has been diagnosed with.

Diagnosis	When?	Who Diagnosed?	Type of Treatment
Attention Deficit Hyperactivity Disorder			
Conduct Disorder			
Oppositional Defiant Disorder			
Autism/Asperger's Disorder			
Pervasive Developmental Disorder			
Depression			
Bipolar Disorder			
Anxiety			
Obsessive Compulsive Disorder			
Posttraumatic Stress Disorder			
Reactive Attachment Disorder			
Schizophrenia			
Fine or Gross Motor Impairment			
Learning Disability (Specify type)			
Speech/Language Disorder			
Other:			

Check all services received (past and present).

Treatment	When	Where	How did it work?
Medication for emotional/behavioral problems			
Therapy/Counseling			
Drug or alcohol treatment			
Psychiatric hospitalization			
Psychological/Neuropsychological testing			
Speech/Language testing			
Any other tests or evaluations			

Please list all PREVIOUS medications (prescription or over-the-counter) your child has ever used for emotional or behavioral problems.

Medication Name & Dose	Start/Stop Dates	Why prescribed	Why Was It Stopped?

Please list all CURRENT medications your child takes for any condition (medical or psychiatric).

Medication Name & Dose	Start Date	For What Reason	Is It Working?

List any medications that have caused severe side effects or an allergic reaction. _____

_____

_____

Does your child remember to take his/her own medications? YES NO

Is your child fully responsible for taking his/her own medications? YES NO

SAFETY ASSESSMENT

Does your child/adolescent have a history of suicidal thoughts or attempts? YES NO

If Yes, describe: _____

Does your child/adolescent injure him/herself on purpose (e.g., cutting, head banging)? YES NO

If Yes, describe: _____

Does your child/adolescent have access to dangerous objects (e.g., guns, knives, medications)? YES NO

If Yes, describe: _____

Does your child/adolescent use alcohol, tobacco, or other drugs including prescription drugs? YES NO

If Yes, describe: _____

Has your child/adolescent ever experienced physical, sexual, or emotional abuse? YES NO

If Yes, describe: _____

FAMILY HISTORY

Who lives in the child's home? Please include yourself and step- or half-siblings who may be there part-time.

Name	Relationship to Child	Age	How does the child get along with this person?
			Poor Average Good
			Poor Average Good
			Poor Average Good
			Poor Average Good
			Poor Average Good
			Poor Average Good

Who else is significant in the child's life, but does not live in the home (e.g., step- or half-siblings, grandparents)?

_____

_____

Child's biological parents are:

____Married ____Divorced ____Never married ____Do not have custody

If there is a legal custody or visitation agreement, please describe: _____

_____

Is the child adopted? YES NO **If yes, does the child know?** YES NO

Please describe the highest level of education (e.g., finished high school, some college) & current employment for the following people:

Parent	Current Age	Highest Grade Completed	Currently Employed As:
Biological Mother			
Biological Father			
Step / Adoptive / Guardian Mother			
Step / Adoptive / Guardian Father			

Have you or any other member of the child's family (e.g. child's sister, uncle, grandmother) experienced any of the following conditions?

FAMILY PSYCHIATRIC/BEHAVIORAL HISTORY		FAMILY MEDICAL HISTORY	
Condition	**Who?**	**Condition**	**Who?**
Aggression / Defiance		Allergies / Asthma	
Alcohol / Drug Problems		Cancer	
Arrests		Congenital (Birth) Defects	
Autism		Diabetes	
Attention Problems		Epilepsy (Seizures)	
Bipolar Disorder		Heart Disease	
Depression		High Blood Pressure	
Eating Disorders		Mental Retardation	
Hyperactivity		Migraines	
Learning Problems		Speech / Language Problems	
Nervousness / Anxiety		Tics	
Schizophrenia		Other:	
Suicide			
Other:			

CHILD'S HEALTH HISTORY

Has your child EVER experienced any of the following medical conditions? Check if YES.

_____ Loss of consciousness	_____ Chronic ear infections	_____ Constipation
_____ Seizures/Convulsions	_____ Hearing impairment	_____ Appetite problems
_____ Staring Spells	_____ Vision Impairment	_____ Weight Changes
_____ Head Injury	_____ Joint Aches	_____ Bowel/Bladder Problems
_____ Difficulty with memory	_____ Muscle Aches	_____ Sleep problems
_____ Dizziness	_____ Breathing Problems	_____ Handwriting problems
_____ Encephalitis	_____ Heart Irregularities	_____ Speech/languaç e problems
_____ Meningitis	_____ Heart Burn	_____ Skin Problems
_____ Numbness	_____ Bloating	_____ Obsessive Thoughts
_____ Clumsiness	_____ Food Intolerance	_____ Repetitive Behaviors
_____ Headaches	_____ Diarrhea	_____ Other (Describe Below)

Has your child had any serious illnesses, operations or hospitalizations? If yes, please explain. _____

_____

List any physical concerns (e.g., head injury, seizures) your child experienced in the past. _____

_____

Has your child had any diagnostic tests (e.g., EEG, MRI, CT Scan)? If yes, please explain. _____

_____

What time does your child typically go to bed?_____ **Wake up?** _____

Does your child have any difficulty falling asleep at night? YES NO **When did this start?** _____

How much does your child typically eat? NOT ENOUGH RIGHT AMOUNT TOO MUCH

PREGNANCY AND DELIVERY

Length of pregnancy_____ Child's Birth Weight_____

Mother's age when child was born_____ Child's Birth Length___

Did any of the following occur for the MOTHER during pregnancy or delivery?

Problem	If YES, please explain
Serious illness or injury	
Hypertension	
Diabetes	
Took prescription medications	
Took illegal drugs	
Drank alcoholic beverages	
Smoked cigarettes	
Had a cesarean (C-section) delivery	
Other complications	

Did any of the following happen to the CHILD shortly after delivery?

Problem	If YES, please explain
Injured during delivery	
Needed oxygen	
Born with congenital (birth) defect	
Stayed in hospital longer than mom	

Describe any complications with the child's birth and newborn period._____

_____

DEVELOPMENTAL HISTORY

Please indicate at what age your child first did the following:

Sat alone _____ Used single words _____

Walked alone _____ Toilet trained _____

Compared to other children, the child's development was: LATE ON TIME EARLY

Please describe any problems during child's development:_____

_____

CHILD'S ADJUSTMENT AND BEHAVIOR

List the child's three greatest strengths:

1. _____
2. _____
3. _____

Does your child have any problems controlling his/her behavior? YES NO

What techniques (e.g., time-out, removing privileges, rewards) are helpful in managing your child's behavior?

_____

_____

What techniques have you used that have been unsuccessful?

_____

_____

SCHOOL INFORMATION

Name of school: _____

School District: _____

Teacher's Name: _____ **Grade:** _____

School Counselor's Name: _____

Type of classroom child is currently in:

_____Regular _____Special Ed Resource Service

_____Home school _____Other: _____

Has your child repeated a grade? YES NO **Which grade(s)?** _____

What kind of grades does your child typically receive? _____

Are any subjects particularly challenging for your child? _____

_____

Does your child need extra help or special services at school? YES NO

Does your child have a formal IEP or 504 Plan? YES NO

If YES, please describe and provide a copy: _____

_____

Has your child undergone any testing (e.g., IQ, Academic Achievement) through the school district? YES NO

If yes, please identify dates and obtain reports from school. _____

Is there any additional information that would assist us in understanding your child/adolescent?

Is there any additional information that would assist us in understanding your current concerns or problems?