



Developmental Consultation

Name of Child: _____ Person Completing Form: _____ Date: _____

DOB: _____ Age: _____ Grade: _____ School: _____ PCP: _____

Accompanied By: _____ Relationship to Child: _____ Are you the legal guardian? Y N

I. History

Please download this ahead of time from www.melmedcenter.com for future visits!

A. What is your chief concern / current diagnosis? _____

B. Interval History: (HPI) (B Section for doctor only) _____

Include: quality _____ duration since _____ severity _____ context home/school _____
 changes _____ modifying factors _____ associated symptoms _____

C. What current interventions is your child receiving?

None Melmed Center Services _____ Other _____

IEP/504 Plan ST/OT/PT Habilitation/Respite Care ABA Counseling

Social Group AZEIP DDD/ALTCS Nutrition Develop preschool

D. What current medications or supplements is your child taking? None Inconsistent

<u>Name</u>	<u>Name</u>
1. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only	5. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only
2. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only	6. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only
3. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only	7. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only
4. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only	8. _____ Dose _____ <input type="radio"/> Daily <input type="radio"/> M-F only

Medication Allergy? No Yes _____ Medications are effective Yes No

Please complete the next pages.



Name of Child: _____ Date of Visit: _____

Symptom Checklist Parent (Vanderbilt Modified Form)

Please rate each symptom by circling the number that best describes the symptoms or severity of challenge.

Frequency Code: 0 = Never 1 = Occasionally 2 = Often 3 = Very Often

0 1 2 3	Fails to give attention to details or makes careless mistakes
0 1 2 3	Has difficulty sustaining attention in tasks
0 1 2 3	Does not seem to listen when spoken to directly
0 1 2 3	Difficulty following instructions and fails to complete assigned tasks
0 1 2 3	Has difficulty organizing tasks
0 1 2 3	Avoids or dislikes tasks that require sustained mental effort.
0 1 2 3	Loses things necessary for tasks
0 1 2 3	Is easily distracted by extraneous stimuli
0 1 2 3	Is forgetful in daily activities
0 1 2 3	Fidgets with hands or feet or squirms in seat
0 1 2 3	Difficulty remaining seated when expected
0 1 2 3	Runs about or climbs excessively at inappropriate times
0 1 2 3	Has difficulty playing quietly
0 1 2 3	Is "on the go" or often acts as if "driven by a motor"
0 1 2 3	Talks excessively
0 1 2 3	Blurts out answers before questions complete
0 1 2 3	Has difficulty awaiting turn
0 1 2 3	Interrupts or intrudes on others
0 1 2 3	Difficulty with homework completion
0 1 2 3	Problematic school performance
0 1 2 3	Difficulty in social situations with peers
0 1 2 3	Challenges in the morning routine
0 1 2 3	Difficulty with time management
0 1 2 3	Difficulty with siblings
0 1 2 3	Difficulty managing anger or disappointment
0 1 2 3	Oppositional with parents
0 1 2 3	Aggressive verbally
0 1 2 3	Aggressive physically
0 1 2 3	Mood changes quickly and drastically
0 1 2 3	Less social with friends, looks dull or flat
0 1 2 3	Is tired during the day
0 1 2 3	Is dull, flat, "loss of spirit" not him or herself
0 1 2 3	Is worried or anxious about things
0 1 2 3	Is sad, depressed, low mood, tearful
0 1 2 3	Is irritated easily by things or crabby feeling
0 1 2 3	Reacts emotionally i.e. yelling, slamming doors
0 1 2 3	Tics or movements, twitches, jerks or noises
0 1 2 3	Habits such as nail biting or skin picking
0 1 2 3	Decreased appetite
0 1 2 3	Difficulty falling asleep

