melmed center

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. Chief Complaint: _____

_____

_____

_____

B. Current Interventions:

○ None ○ Melmed Center Services _____ ○ Other _____

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

○ Social Group ○ AZEIP ○ DDD/ALTCS ○ Nutrition ○ Develop preschool

C. Current Medications/Supplements: ○ None ○ Inconsistent

	Name					Name			
1.	_____	Dose ____	○ Daily	○ M-F only	5.	_____	Dose ____	○ Daily	○ M-F only
2.	_____	Dose ____	○ Daily	○ M-F only	6.	_____	Dose ____	○ Daily	○ M-F only
3.	_____	Dose ____	○ Daily	○ M-F only	7.	_____	Dose ____	○ Daily	○ M-F only
4.	_____	Dose ____	○ Daily	○ M-F only	8.	_____	Dose ____	○ Daily	○ M-F only

Medication Allergy? ○ No ○ Yes _____ Medications are effective ○ Yes ○ No

D. Review of Systems

CONSTITUTIONAL / GENERAL	EYES	CARDIO	GASTRO-INTESTINAL	MUSCULOSKELETAL	NEUROLOGY	ALLERGY
○ Fatigue ○ Jaundice ○ Wt gain / loss ○ Fever ○ Other	○ Blurred Vision ○ Strabismus / Lazy Eye ○ Double Vision ○ Tearing ○ Eye pain ○ Other	○ Dizziness ○ Palpitations ○ Fainting / Near Fainting ○ Chest pain ○ Swollen Hands or Feet ○ Fast Heart Rate ○ Other	○ Abdominal pain ○ Appetite increase / decrease ○ Constipation ○ Diarrhea ○ Encopresis / Soiling ○ Nausea / vomiting ○ Reflux / Heart Burn ○ Other	○ Muscle ache ○ Weakness ○ Bone pain ○ Joint pain / swelling / Redness ○ Other	○ Headache ○ Tics / Eye Blinking / Twitches / Throat Clearing ○ Seizure ○ Involuntary movements ○ Tremors ○ Staring Spells ○ Stimming ○ Jerky Movements	○ Food ○ Seasonal ○ Environmental ○ Other **HEMATOLOGIC/ LYMPHATIC** ○ Bleeding ○ Easy Brusining ○ Other
○ None	○ None	○ None	○ None	○ None	○ None	○ None

ENDOCRINOLOGY	ENT	RESPIRATORY	GU	SKIN	MENTAL HEALTH	SLEEP
○ Breast Growth ○ Early Puberty ○ Short Stature ○ Poor growth ○ Excessive Hairiness ○ Other	○ Ringing ○ Vertigo / Room Spinning ○ Sore Throat ○ Nasal / ear discharge ○ Nasal Congestion ○ Other	○ Cough ○ Wheezing ○ Nasal Congestion ○ Shortness of Breath ○ Asthma ○ Other	○ Bed Wetting ○ Daytime Wetting ○ Painful Urination ○ Abnormal Periods / Menstrual bleeding ○ Dark Colored Urine ○ Not toilet trained ○ Other	○ Discoloration ○ Rashes ○ Itching ○ Hair loss ○ Skin picking ○ Hair Pulling ○ Cutting ○ Acne ○ Other	○ Anger/agitation ○ Crying ○ Irritability ○ Anxious ○ Mood Swings ○ Depression ○ Suicidal Thoughts ○ Self Harm ○ Aggression ○ Other	○ Night waking/Early Morning Waking ○ Day Time Sleepiness ○ Difficulty Falling Asleep ○ Nightmares/Terrors ○ Teeth Grinding ○ Snoring / Apnea ○ Day Time Wetting ○ Other
○ None	○ None	○ None	○ None	○ None	○ None	○ None

melmed center

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