melmed center

WELCOME!

We appreciate you reviewing the following information in its **entirety & initialing.**

You will be given a copy of your signed Welcome Letter for your records.

Melmed Center has a large team of different care providers including Developmental Pediatricians, Psychiatric Nurse Practitioners, Psychologists, Occupational Therapists, Board Certified Behavior Analysts, Registered Behavior Technicians, and Educational Specialists.

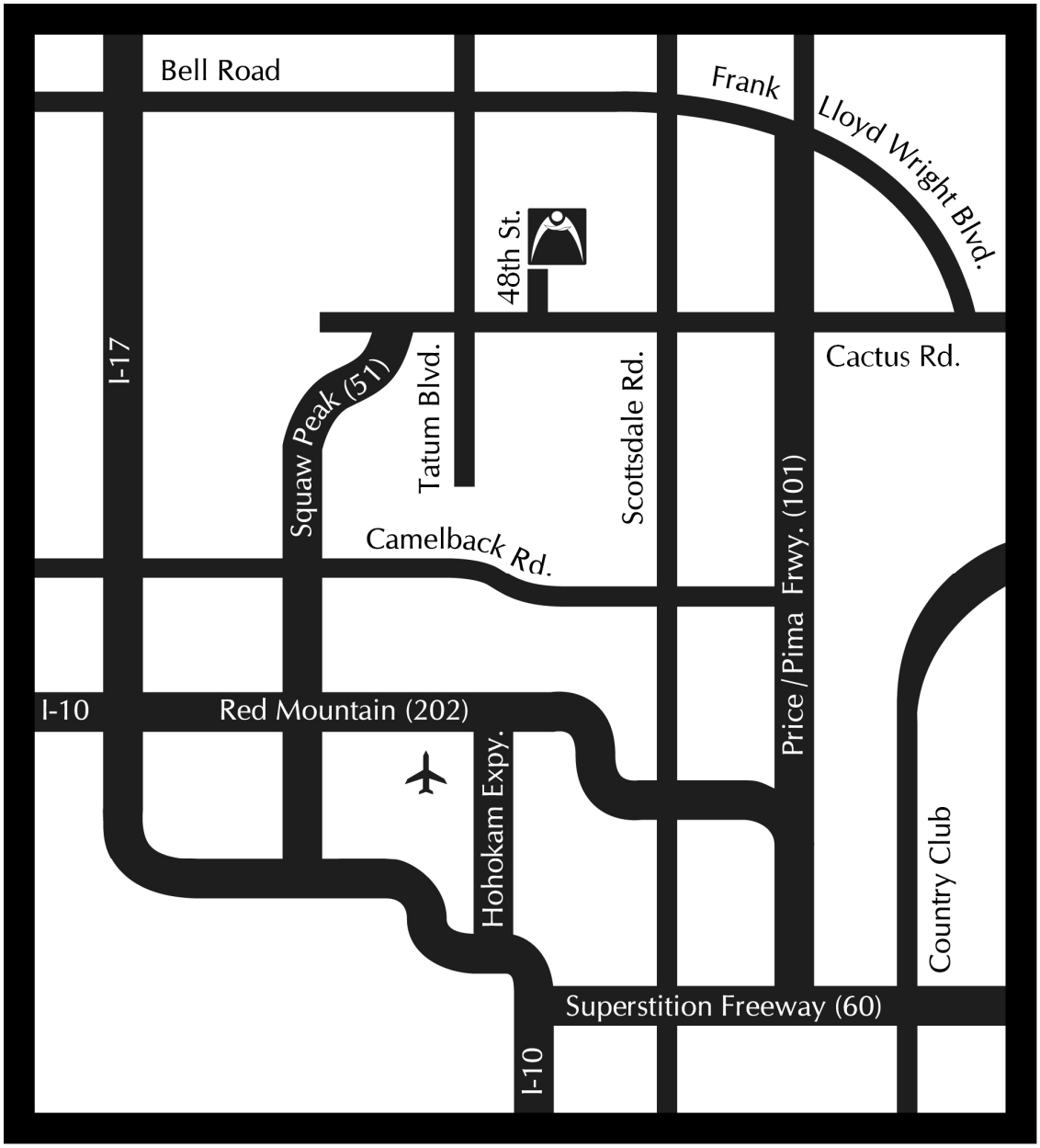
Our goal is to provide our patients with the best possible service. We have listed important items below that will assist us in providing that care. ***Please keep on file for future reference!***

- If you have insurance that our office participates with, please bring your ID card and any necessary forms to ensure proper billing. If your insurance requires a referral, please contact your primary care physician to secure the referral **PRIOR** to each visit. **Failure to do so may result in the cancellation of your appointment or your payment will be out of pocket at time of service.** Since insurance companies have many exclusions of coverage, we suggest that you check with your plan to ensure coverage before your visit. ***Initial:*** _____
- If you **do not** have insurance that our office participates with, we are happy to provide a copy of the attending doctor's superbill for you to submit to your insurance company. ***Initial:*** _____
- Our Psychologists and Therapists are **not** contracted with **any** insurance companies, even if your other medical services at the Melmed Center are covered. Therefore, payment for services is **due at the time of each visit**. ***Initial:*** _____
- **ALL payments are due at the time of ANY service.** Payments can be made by MasterCard, Visa, Discover, check or cash. ***Initial:*** _____
- If your child is being evaluated for learning differences, please bring copies of report cards. Also, please remember to **bring glasses, hearing aids, et cetera** as needed. To obtain the best results, your child should be **well rested** and have had a **healthy meal** prior to the appointment. If your child is on medication for ADHD, please give it to him/her prior to the evaluation. ***Initial:*** _____
- If you have a sensitive situation that will require a private discussion between parent and doctor, **two adults must be present** at the appointment, one to speak with the doctor & one to sit with the child in the waiting room. We do not have daycare and are NOT liable if a child is left unattended. ***Initial:*** _____
- Our providers are NOT responsible to communicate information regarding a visit to a non-attending parent/guardian. Our providers will NOT be calling the non-attending parent/guardian. If it is imperative the non-attending parent/guardian speak to the provider a phone consultation must be made and the fee is NOT covered by insurance. ***Initial:*** _____
- If an adult other than the legal parent or guardian will be bringing the patient to any appointment at Melmed Center, a consent form must be completed **in advance**. ***Initial:*** _____
- Please bring the **completed** Melmed Center packet, **a family picture**, and **copies**, of any previous evaluations that you would like your care provider to have at the initial appointment. As a courtesy, we will duplicate such records at 15 cents per page if you are not able to bring copies. ***Initial:*** _____
- We do **require** confirmation of all new patient appointments, one week prior to the scheduled appointment. Cancellations must be made **48 hours** in advance. You ***will be charged*** if the reserved appointment is not cancelled within 48 hours prior to the scheduled appointment time. The charge will depend on the type of appointment you have scheduled. (If you have further questions about the cancellation fees please contact our office.) ***Signature:*** _____
- You will receive a report **4-6 weeks after** your initial evaluation, it is complimentary. However, there is a charge for additional copies of the report. ***Initial:*** _____
- Our Clinicians are dedicated to returning messages within **24-72 hours**. Please be patient! Do **not** call several times if you have not heard from your clinician immediately. Our Clinicians see patients back-to-back every day and WILL return your call within the allotted time stated above. For emergencies, call 9-1-1. ***Initial:*** _____
- Melmed Center reserves the right to refuse/discharge a patient from treatment and/or services. ***Initial:*** _____
- Audio/video recording is prohibited without written consent from the provider. ***Initial:*** _____
- If the complexity of care is beyond the scope of our practice, the patients will be discharged and referred to an appropriate medical/psychiatric provider. ***Initial:*** _____

Our primary purpose is to provide you with the highest quality developmental pediatric care with courtesy and understanding. Our success can only be measured by your satisfaction with the care you receive. We encourage your feedback on how we may satisfy your needs. By signing here, I understand all policies stated above & will keep for future reference.

Signature: _____ Patient Name: _____ Date: ____/____ (mm yyyy)

We are located at 4848 East Cactus Road, Suite 940 in Scottsdale, AZ on the NE corner of 48th St. and Cactus Road. We are behind Red Lobster and Olive Garden. (see map on back of page)



4848 East Cactus Road, Suite #940 Scottsdale, AZ 85254 (480) 443-0050
www.melmedcenter.com

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INFORMED CONSENT FOR TELEHEALTH SERVICES

What is Telehealth?

Telehealth is “the use of telecommunication and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.” Telehealth allows Melmed Center providers to diagnose, consult, treat and educate using interactive audio, video or data communication.

I hereby consent to participating in medical treatment, psychotherapy and ABA therapy via telephone or internet with Melmed Center. Telehealth services may be provided by a Developmental Pediatrician, Psychiatric Nurse Practitioner, Clinical Psychologist, Psychiatrist, Counselor, Educational Specialist, Occupational Therapist, BCBA, ABA Behavioral Technician, Nutritionist or a medical assistant.

Potential Risks with Telehealth

A potential risk of telehealth is telehealth services may not be appropriate for all patients and a face-to-face consultation still may be necessary.. Melmed Center utilizes secure, encrypted audio/video transmission software to deliver telehealth. In rare circumstances despite reasonable efforts on the part of Melmed Center, security protocols could fail causing a breach of patient privacy. The transmission of personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. During the COVID situation, alternate means of telehealth services have been deemed acceptable.

Alternative Treatment

Providers shall use their clinical judgement to determine if telehealth services are appropriate. The alternative to telehealth consultation is a face-to-face visit with your provider.

Confidentiality

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

Audio/video recording, streaming or capturing telehealth sessions is prohibited without written consent from the provider. MICA has informed us that due to COVID, a verbal consent is now also acceptable.

We may use health information about you to provide medical treatment or services. We may disclose your health information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Personnel in our office may share information about you and disclose information to health care personnel who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy and scheduling lab work.. Family members and other health care providers may be part of your medical care outside this office and may require

information about you that we have. We may leave messages at the numbers provided by you or with a family member unless we receive in writing a request not to receive such communications.

Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room.

Mandatory Reporting

Any physician, nurse practitioner, psychologist, counselor, educational advocate, BCBA, behavior technician or healthcare worker that "have reason to believe" that a child or adult have been subjected to abuse or neglect, including sexual abuse, are required by law to report this abuse and neglect as mandated reporters.

Medical Records

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Melmed Center Privacy officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Rights

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

Telehealth Recommendations for Patients

To protect your confidentiality and security of your information, we recommend the following:

1. Telehealth session should be held in a private location.
2. Use a private computer or phone.
3. Password protect any technology used to interact with your provider.
4. Hang up and log out of session once it is completed.
5. If providers need to reach you via phone, they might use blocked phone numbers.

In case of an emergency and in the event that my clinician is not available, I am advised to contact my primary care physician or call 9-1-1 if one's life is in danger. I am further advised to report to the nearest emergency room if emergency assistance is needed.

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INFORMED CONSENT FOR TELEHEALTH SERVICES

Payment for Telehealth Services

Melmed Center will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. Full insurance co-payment/co-insurance and/or deductible, as well as account balances are due at the time of service. Only credit cards will be accepted.

As health care providers, our relationship is with you, our client, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your health insurance benefits.

In the event that insurance does not cover services provided or telehealth it is the individual's responsibility for any unpaid charges as determined by your insurance company. Private pay rates are available when individuals' insurance carriers do not cover telehealth.

Cancellation

A scheduled appointment means that times is reserved for you. If an appointment is missed or cancelled for any reasons, with less than 48 hours' notice, the patient will be billed according to the scheduled fee. This fee is not generally paid by an insurance company.

Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Name of Patient/Client

_____

Date

_____

Parent/Guardian Name

_____

Parent/Guardian/Patient Signature

_____

Parent or Guardian Signature

_____

Phone Number

_____

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TM

REGISTRATION FORM

MUST BE COMPLETED IN FULL USING A **BLACK** INK PEN

Patient information

Legal Name _____**Date of Birth**_____ **M/F**____
Child lives with: Mother □ Father □ Court Appointed Guardian: _____

Mother / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Mother has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

Father / Court Appointed Guardian Information ***(Paperwork must be provided for legal Guardians)***

Name_____**Date of Birth**_____
Address_____ **City** _____ **State** _____ **Zip** _____
Primary Phone #_____ **Secondary Phone** _____
E-MAIL: _____ ***would you like to receive updates via E-mail?*** **Yes / No**
If parents are divorced or separated, Father has a right to request records and coordinate care? Circle Yes/ No
If no please explain: _____

I authorize Melmed Center to contact me by telephone with medical information pertaining to my child's care. If I am unavailable, this authorization gives Melmed Center permission to leave this information either on my answering machine or with a member of my household.

Authorized Care Givers ***(Other than biological parents/guardians)***
The following people are authorized to discuss personal health information with the Melmed Center. They are also able to coordinate care, schedule and attend appointments and may be contacted in case of an emergency.
(Only parents and legal guardians can request and transfer records)

Name _____ **Relationship** _____**Phone Number** _____

Name _____ **Relationship** _____**Phone Number** _____

PLEASE NOTE IF DIVORCED: LEGAL CUSTODY DOCUMENTS MUST BE PROVIDED

DIVORCED/SEPARATED FAMILIES
We strive to, but cannot always act as a mediator between parents under contentious circumstances. We also strive to avoid being "side-barred" by parents, lawyers or other professionals; and we hope that is respected. Both parents are always welcome, explicitly and implicitly, at all visits; indeed that is preferred. Parents are responsible for ensuring that coordination of each of their own schedules allows for both to be present. This of course requires a degree of cooperation, that if absent, will preclude the most optimal evaluation. If communication challenges exist which preclude that, it is unfortunate, especially for the child. Melmed Center will work with both parents. Therefore, it is required that you complete both parents information above unless the court dictates otherwise. Furthermore, payment must be arranged by the time of the visit. We accept payment in advance, but require it from the accompanying adult at the time of the appointment.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____
Signature of Parent/Legal Guardian

Please turn the page over and complete the other side →

melmed center

TM

REGISTRATION FORM

MUST BE COMPLETED IN FULL USING A **BLACK** INK PEN

*****PLEASE READ***CANCELLED/MISSED APPOINTMENTS*****

A SCHEDULED APPOINTMENT MEANS THAT TIME IS RESERVED ONLY FOR YOU. IF AN APPOINMENT IS MISSED OR CANCELLED FOR ANY REASON, WITH LESS THAN 48 HOURS NOTICE, THE PATIENT WILL BE BILLED ACCORDING TO THE SCHEDULED FEE. THIS FEE IS NOT GENERALLY PAID BY AN INSURANCE COMPANY.

Signature: _____ Date: _____

PRESCRIPTION REFILL POLICY

Our office policy is that all prescription refill requests must be made 7-10 working days in advance of running out of the medication. Refills will only be approved if follow up visits have been kept **every 2-3 months**.

Prescriptions will be handled only during office hours. ***Initial*: _____**

The Melmed Center has therapy/service animals in our office. **It is your responsibility** to notify our office, **prior to your appointment**, if you have fear of, or allergies to dogs. Melmed Center will not be held liable for any incidents such as licking, nibbling, or physical contact from the dog(s). By signing this document you are aware we do have service/therapy animals in our office. Please contact us if you have any further questions.

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/co-insurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies.

Please understand that we will only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause. This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that are not kept current may be subject to collection and associated fees.

Please note: Insurance cannot be billed without the patient present. Upon request you may schedule a parent consultation with your child's provider for a private pay fee.

By completing the information below, you assign your insurance benefits to be paid directly to Melmed Center. You also authorize Melmed Center to release any information which may be needed for processing all of claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, **we require notification of insurance changes at least one week prior** to your appointment to avoid appointment delay and/or private pay expenses.

Insurance Company: _____ Phone: (___)_____ Employer: _____

Group/Policy#: _____ ID#: _____ Employee SS#: _____

Employee/Insured's name: _____ DOB: _____

Insurance Mailing Address: _____

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance card (i.e. Medco, Prescription Solutions, Caremark, and Express Scripts), **if not, we do need this information filled out in its entirety.**

Pharmacy Benefit Provider: _____

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ Date _____

Signature of Parent/Legal Guardian

Consent for Purposes of Treatment, Payment, and Health Care Operations

melmed center

The following information is pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand I have the right to review Melmed Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Melmed Center. Melmed Center reserves the right to change the Notice of Privacy Practices at any time without notice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy or asking for one at the time of my next appointment. The Notice of Privacy Practices is always available at www.melmedcenter.com.

I consent to the use or disclosure of my protected health information by Melmed Center for the purpose of diagnosing or providing treatment to myself, my child, or my family; obtaining payment for my health care bills, or to conduct health care operations of Melmed Center. "*The Privacy Rule protects all individual identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *'protected health information (PHI).' Individual identifiable health information* is information, including demographic data, that relates to:

- **The individual's past, present or future physical or mental health or condition,**
- **The provision of health care to the individual, or**
- **The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g, name, address, birth date, Social Security Number, etc...)."**

I have been informed that a member of Melmed Center, which may include a Developmental Pediatrician, Psychiatric Nurse Practitioner, Clinical Psychologist, Psychiatrist, Educational/Vocational Advocate, Occupational Therapist, Naturopathic Doctor, BCBA, ABA Behavioral Technicians or a medical assistant, will conduct an evaluation on me, my child, or my family. An evaluation may consist of clinical interviews, behavioral observations, and review of history, psychological assessment, educational assessment, medical assessment, school visits, home visits, and/or administration of assessment instruments chosen specifically for myself, my child, or my family by the clinician. I understand that the clinicians at the Melmed Center work as a multidisciplinary team and therefore one or more clinicians in the practice may see me. I will be informed regarding who my treating clinician will be and I may choose a specific clinician if I so desire. The Melmed Center serves as a training site for several medical and psychological educational programs in Arizona. I may be asked if I consent to have a student, intern, or resident present during the evaluation, intervention, or therapy, and may consent or decline as I wish.

If one or several member(s) of my family participate in the evaluation, therapy, or intervention process, the clinicians have consent to communicate with all family members regarding any issues relevant to the assessment or treatment of any one family member or the family as a whole. I consent to the exchange of verbal and/or written information between the professional team members regarding the care of myself and/or my family. I recognize that unless I have previously expressed my disagreement in writing, Melmed Center has understood that I want them to speak with my parents or guardians about any and all Melmed Center business. This authorization is in effect until such time as I revoke it in writing.

In case of an emergency and in the event that my clinician is not available, I am advised to contact my primary care physician or call 9-1-1 if one's life is in danger. I am further advised to report to the nearest emergency room if emergency assistance is needed.

I understand e-mail communication is a convenience and not appropriate for emergencies or time-sensitive issues. It may take the clinician up to two weeks to receive e-mail, provided they are in the office as regularly scheduled. Melmed Center cannot guarantee the security and privacy of e-mail messages and other staff may read and process the mail, thus highly sensitive or personal information should not be communicated via e-mail. Melmed Center is not responsible for information loss due to technical failures.

I understand that if I choose to sign up for e-mail marketing and/or submit to any online media sights Melmed Center is not responsible for any connection between myself, my family and/or my friends and the center. Media such as Facebook is specifically used for marketing and should not be used as a contact between myself and provider.

Since the clinicians at the Melmed Center can best serve patients when up-to-date medical, educational, and psychological information is available, I consent to have the clinician review all records related to the care, growth and development of the patient. I agree to provide all relevant records specifically including, but not limited to, personal knowledge, intake summaries, treatment plans, progress notes, psychological and developmental history, medical records, physical examinations, psychiatric and psychological evaluations, consultation reports, psychological test results, diagnostic records, educational, social, vocational, speech, occupational and physical therapy records, and legal records. This will serve as notice that Melmed Center reserves the right to disclose protected health information to any local, state, or federal health or law enforcement agency at any time without obtaining consent, if our professional judgment deems it necessary.

Treatment: We may use health information about you to provide medical treatment or services. We may disclose your health information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We may leave messages at the numbers provided by you or with a family member at that number unless we receive in writing a request not to receive such communications.

Payment: We may use and disclose your health information so that the treatment and services you receive at this office may be billed to, and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose your health information in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose your health information in response to a subpoena.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

With the exception of the patient's Primary Care Physician, we will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose your health information, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose your information for the reasons covered by your written *Authorization,* but we can not take back any uses or disclosures already made with your permission.

It is understood that the clinician will provide an evaluation summary to the referral source and/or my primary care physician for coordination of care. By providing the name of my primary care physician below, I consent to the exchange of information between Melmed Center and the following Health Care Provider. Verbal and/or written exchange of information may occur between Melmed Center medical and educational professionals.

Primary Care Physician (Please Print): _____ Telephone: _____

Address: _____ City: _____ State: ____ Zip: _____

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a *written* request to Melmed Center Privacy officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe your health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information was generated and is kept by this office.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in *writing* to Melmed Center Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are NOT required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to Melmed Center Privacy Officer. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Revoke your Consent: you can revoke your consent at any time by giving us *written* notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

I consent to the evaluation, treatment, or intervention of my child. I certify that this consent has been given freely and voluntarily. By my signature below, I acknowledge that I understand and agree to the above information.

_____ _____

Name of Patient (Please Print) Today's Date

_____

Signature of Parent/ Legal Court Appointed Guardian

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Child Intake Questionnaire

In order to serve you better, please complete all of the following questions. Feel free to add any extra comments in the spaces provided on the front or back cover. Please use a black pen, and bring the finished questionnaire to your appointment.

Date of completion: _____ / _____ / _____ Date of visit: _____ / _____ / _____

PERSONAL INFORMATION

Name of child: (FIRST) _____ (MI) _____ (LAST) _____
Date of birth: _____ / _____ / _____ Age: _____ Gender: _____
Ethnicity: _____ Primary language: _____
School: _____ Grade: _____
Your name: (FIRST) _____ (MI) _____ (LAST) _____
Your relationship to child: _____
Who is the child's primary care doctor? _____

A. YOUR EXPERIENCE & INSIGHTS

1. What are your chief concerns about your child? _____

_____

_____

a. When did you first notice these concerns? _____

b. Who else have you seen for these concerns? (Please provide copies of existing evaluations)

_____

_____

c. What has already been done to treat these concerns? (Medications, diet, counseling)

_____

_____

d. What have you done, personally, to address these concerns? _____

_____

_____

_____

e. What seems to help the most? _____

_____

2. Please tell us about your child's most outstanding characteristics, hobbies, abilities, and/or any other strengths: _____

_____

3. What have you told your child about this visit to Melmed Center? _____

_____

_____

_____

B. BIRTH HISTORY

1. During the pregnancy, did the biological mother have: *(Please check all that apply)*

○ None	○ German measles	○ Kidney problems
○ High blood pressure	○ Vaginal bleeding	○ Amniocentesis
○ Vaginal infections	○ Other infections	○ Anemia
○ Diabetes	○ Emotional problems	○ No prenatal care
○ Premature labor	○ Excessive weight gain	○ Family stress
○ Exposure to toxins (paint, solvents, toluene, etc.)		○ High fevers

a. Please comment briefly on any checked response(s): _____

_____

2. Were any fertility treatments used in this pregnancy? ○ Yes ○ No

a. If yes, please describe: _____

_____

3. During the pregnancy, did the biological mother use:

○ Medications ○ Street drugs ○ Alcohol ○ Tobacco

a. Please comment on any checked response(s): _____

_____

4. During the delivery, was anesthesia used? ○ Yes ○ No

a. If yes, what type? _____

5. Was labor induced? ○ Yes ○ No

a. If yes, by what? _____

6. How long did the pregnancy last? _____ Months

7. How long was the labor? _____ Hours

8. What was the baby's birth weight? _____ Lbs. _____ Oz.

9. Baby was born: ○ Vaginally ○ Caesarean section

10. Did the baby have: *(Please check all that apply)*

○ None	○ Trouble breathing	○ Physical injuries
○ Birth defects	○ Yellow jaundice	○ Cord around neck
○ Twin	○ Blood transfusion	○ Fevers/low temp
○ Seizures	○ Resuscitation	○ Trouble sucking
○ Intensive care	○ Jitteriness	

a. Please comment briefly on any checked response: _____

_____

11. How long did the baby stay in the hospital? _____

12. Were there any other concerns or issues during this pregnancy or birth not covered by the above questions? _____

13. Was the baby:

a. Breast-fed ○ Yes ○ No

If Yes, how long? _____

b. Bottle-fed ○ Yes ○ No

c. Any early feeding problems? ○ Yes ○ No

If yes, explain: _____

14. What is the pregnancy history of the biological mother?

a. How many previous pregnancies? _____

b. How many previous pregnancies to term? _____

15. Please list any other problems or concerns on the part of the parents or doctors:

_____

C. ADOPTION INFORMATION

(If this section does not apply, continue to section D)

1. Does your child know of the adoption? ○ Yes ○ No

a. If not, do you intend to tell him or her? ○ Yes ○ No

2. At what age was the child placed in your home? _____

3. At what age was the child adopted? _____

D. MEDICAL HISTORY

1. Does your child have any: *(Please check all that apply)*

a. Sleep problems

○ None ○ Falling asleep ○ Staying asleep
○ Sleepwalking ○ Nightmares
○ Excessive snoring ○ Teeth grinding
○ Excessive sleeping

b. Brain disorders

○ None ○ Headache ○ Seizures
○ Motor/vocal tics ○ Fainting spells
○ Tremors ○ Confusion
○ Muscle weakness ○ Staring spells
○ Head injury ○ Unusual movements
○ Coordination difficulties

c. Lung problems

○ None ○ Short of breath ○ Asthma
○ Coughing

d. Skin disorders

○ None ○ Acne ○ Hair loss
○ Birth marks ○ Eczema

e. Blood disorders

○ None ○ Anemia ○ Bleeding
○ Bruising

f. Heart problems

○ None ○ Chest pain ○ Surgery
○ Congenital heart ○ QT Syndrome

g. Sexuality

○ Normal ○ Masturbation excess ○ Promiscuity
○ Menstruation ___ mo. ___ yr. ○ Birth control

h. Kidney problems

○ None ○ Infections ○ Bedwetting
○ Reflux ○ Bladder infection

i. Muscle and bone problems

○ None ○ Scoliosis ○ Injuries
○ Spasticity ○ Low tone

j. Allergies

○ None ○ Seasonal ○ Food
○ Environmental ○ Medication

Please list allergies: _____

k. Gland problems

○ None ○ Obesity ○ Thyroid problem
○ Slow Growth ○ Fast growth
○ Early puberty ○ Delayed puberty

l. Stomach and bowel problems

○ None ○ Diarrhea ○ Vomiting
○ Constipation ○ Stomachaches
○ Stool soiling ○ Mushy stools
○ Excessively gassy ○ Foul smelling stools
○ Alt. diarrhea/ constipation ○ Sandy stools
○ Night-time waking with irritability

m. Infectious diseases

○ None ○ Yeast infections ○ Measles
○ Mumps ○ Whooping cough
○ Unexplained high fevers ○ Strep infections

n. Eye problems

○ None ○ Wears glasses ○ Strabismus
○ Surgery ○ Visual impairment

o. Ear problems

○ None ○ Ear infections ○ Hearing loss
○ PE tube placement

p. Please comment further on any of the above which were checked: _____

_____

_____

2. Has your child ever been poisoned? *(lead, chemicals, other)* ○ Yes ○ No

a. If yes, please specify: _____

3. Has your child been exposed to any toxin/chemical? ○ Yes ○ No

a. If yes, please explain: _____

4. Are your child's immunizations up to date? ○ Yes ○ No

a. If no, what is missing? _____

5. Please complete if your child has ever been hospitalized or had outpatient surgeries or procedures.

Age	Reason
_____	_____
_____	_____
_____	_____

6. a) Please list all current and past medications that this child has taken to help with behavioral or emotional problems, as well as other chronic conditions.
(We need to be aware of due to possible medication interactions.)

Age Start - Stop	Medicine	Doctor	Reason	Currently Taking
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○

b) Please list all current and past supplements, remedies, nutriceuticals or vitamin products that this child takes.

Age Start - Stop	Medicine	Doctor	Reason	Currently Taking
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○
____ - ____	_____	_____	_____	○

7. Please list any special diets your child follows: _____
_____

8. Do you have any concerns about your child's diet? ○ Yes ○ No
a. If yes, what are they? _____
_____
_____

9. Please list any special diagnostic tests (X-rays, EEG, MRI, CT scan, blood tests, hearing test) your child has undergone.

Age	Test	Reason	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Most recent hearing screen? Date ____ / ____ / ____ ○ Pass ○ Fail

11. Most recent vision screen? Date ____ / ____ / ____ ○ Pass ○ Fail

12. Have you ever suspected child was physically/sexually abused? ○ Yes ○ No
a. If yes, please explain: _____
_____

13. Is your child left or right handed? ○ Left ○ Right

E. EARLY DEVELOPMENT

1. At about what age did your child first: (approximately)

a.	Sit up?	Age ____	○ On time	○ Early	○ Late
b.	Crawl?	Age ____	○ On time	○ Early	○ Late
c.	Stand alone?	Age ____	○ On time	○ Early	○ Late
d.	Speak real words?	Age ____	○ On time	○ Early	○ Late
e.	Walk by self?	Age ____	○ On time	○ Early	○ Late
f.	Feed self?	Age ____	○ On time	○ Early	○ Late
g.	Use two-word sentences?	Age ____	○ On time	○ Early	○ Late
h.	Speak so that strangers could understand?	Age ____	○ On time	○ Early	○ Late
i.	Dress self (except for buttoning or tying)?	Age ____	○ On time	○ Early	○ Late

Continued: At about what age did your child first:

j. Pedal a tricycle? Age ____ ○ On time ○ Early ○ Late

k. Ride a bicycle without training wheels? Age ____ ○ On time ○ Early ○ Late

l. Tie own shoes? Age ____ ○ On time ○ Early ○ Late

m. Become toilet trained? Age ____ ○ On time ○ Early ○ Late

2. Do you have any of the following concerns about your child's motor development?

○ None ○ Muscle tone ○ Fine motor
○ Gross motor ○ Handwriting
○ Other _____

3. Do you have any of the following concerns about child's language/speech development?

○ None ○ Unconnected thoughts ○ Following directions
○ Unintelligible ○ Stuttering
○ Too few words in sentences ○ Speech clarity
○ Trouble finding the right word ○ Seems easily confused
○ Repeats words/phrases over and over

4. Has your child ever lost language or regressed? ○ Yes ○ No

a. If yes, how many words? _____

b. If yes, approximately how old was he/she? _____

c. If yes, please explain what may have caused it: _____

_____

5. Has your child ever lost non-verbal communication (i.e. waving)? ○ Yes ○ No

a. If yes, approximately how old was he/she? _____

6. Does your child enjoy playing "dress-up"? ○ Yes ○ No

7. Does your child engage in pretend or make believe games? ○ Yes ○ No

8. Did your child learn pre-academic skills such as numbers, colors, shapes, etc. at the same time as other children his or her age? ○ Yes ○ No

a. If no, please explain: _____

_____

_____

9. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his or her peers? ○ Yes ○ No

a. If yes, please explain: _____

_____

_____

10. Tell us about your child's temperament:

○ Easy going (easily comforted, sleeps well) ○ Slow to warm up
○ Difficult (intense, irritable, sensitive) ○ Other _____

11. Has your child ever been seen by a speech therapist? ○ Yes ○ No

F. ACADEMIC DEVELOPMENT IN SCHOOL AGE CHILDREN

(If this section does not apply, continue to section G)

1. Is your child receiving any special help at school? ○ Yes ○ No

a. If yes, please explain: _____

_____

_____

b. Is there an IEP or 504 plan in place? ○ Yes ○ No

2. What is your impression of your child's learning potential?

○ Slow ○ Average ○ Above average ○ Gifted

3. Do you feel child is performing up to his/her potential in school: ○ Yes ○ No

a. If no, please explain: _____

_____

_____

_____

4. Is homework a problem? ○ Yes ○ No

a. If yes, check all that apply:

- ○ Can't get started
- ○ Forgets to bring home materials
- ○ Doesn't understand the work
- ○ Distracted by TV, radio, anything
- ○ Battles or argues about doing homework
- ○ Needs you by his or her side constantly
- ○ No place to work
- ○ Forgets assignments
- ○ Doesn't anticipate deadlines
- ○ Takes too long
- ○ The most stressful time of day
- ○ Other _____

5. Has your child ever been advanced a grade, retained, suspended or expelled? ○ Yes ○ No

a. If yes, please explain: _____

_____

6. Please list all the schools your child has attended:

_____ _____

_____ _____

_____ _____

_____ _____

7. The following ratings reflect your child's level of specific skills and abilities:

		Good	Fair	Poor	Not Sure
a.	Catching and throwing a ball	○	○	○	○
b.	Playing most sports	○	○	○	○
c.	Drawing/artwork	○	○	○	○
d.	Building things	○	○	○	○
e.	Understanding spoken directions	○	○	○	○
f.	Understanding jokes and stories	○	○	○	○
g.	Telling stories/describing things	○	○	○	○
h.	Remembering telephone numbers	○	○	○	○
i.	Telling time	○	○	○	○
j.	Understanding what he/she reads	○	○	○	○
k.	Rate of reading	○	○	○	○

Continued: The following ratings reflect your child's level of specific skills and abilities:

	Good	Fair	Poor	Not Sure
l. Handwriting	○	○	○	○
m. Writing sentences or paragraphs	○	○	○	○
n. Spelling accuracy	○	○	○	○
o. Learning new math skills	○	○	○	○
p. Knowing what and how to study	○	○	○	○
q. Completing homework	○	○	○	○

G. SOCIAL STYLE & SELF ESTEEM

1. Does your child get along well with others? *(Please check the best responses)*

Makes friends easily	○ Yes	○ No	Has a best friend	○ Yes	○ No
Plays well with others	○ Yes	○ No	Shares easily	○ Yes	○ No
Follows rules	○ Yes	○ No	Enjoys team sports	○ Yes	○ No
Leads other children	○ Yes	○ No	Helps others	○ Yes	○ No
Prefers to be alone	○ Yes	○ No	A party animal!	○ Yes	○ No
Bullies others	○ Yes	○ No	Fights more than others	○ Yes	○ No
Easily influenced	○ Yes	○ No	Prefers adults over peers	○ Yes	○ No

2. My child: *(Please check the best responses)*

Has "I can do it" attitude	○ Yes	○ No	Gives up easily	○ Yes	○ No
Stands up for self	○ Yes	○ No	Recovers from upsets	○ Yes	○ No
Recognizes strengths	○ Yes	○ No	Lacks confidence	○ Yes	○ No
Is adventurous	○ Yes	○ No			

H. YOUR FAMILY

1. Who does your child live with? *(Please check the appropriate response)*

○ Both parents ○ Mom and Step-dad ○ Dad and Step-mom
○ Single parent ○ Shared arrangements ○ Extended family
○ Grandparent ○ Other _____

2. What is your current marital status? *(Please check one)*

○ Single ○Married ○Divorced ○ Widowed ○ Live together/never married

3. Please list the names, occupations and ages of parents or guardians.

Name	Age	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. If divorced from biological parent,

a. What are the custody arrangements? _____

b. Is the non-custodial parent aware of this evaluation? ○ Yes ○ No

5. Please list the names and ages of the other children living at home.

Name	Age	Biological sibling	
_____	_____	○ Yes	○ No
_____	_____	○ Yes	○ No
_____	_____	○ Yes	○ No
_____	_____	○ Yes	○ No

6. Are you satisfied with how the family works? ○ Yes ○ No

a. If no, check all that apply:

○ Lack of structure, rules ○ No family "together times" ○ Poor communication
○ Financial troubles ○ Lack of "breathing space" ○ Marital problems
○ Poor division of chores and responsibilities

b. Any other comments? _____

7. Which of the following family stressors apply to your situation, over the past year? *(Please check all that apply)*

○ Parental separation or divorce ○ Death in family or important friend
○ Severe illness ○ Move to a new home
○ Change of school ○ Loss of job
○ Financial stress ○ Pregnancy/ birth of new child
○ None ○ Other _____

8. Your child's fit in the family: *(Please check all that apply)*

○ Sibling rivalry (more than expected) ○ Spoiled, always gets own way
○ A team player ○ A manipulator
○ A rescuer, can't stand upsets ○ A helper

9. What types of discipline are used in your family? *(Check the appropriate)*

Mother	Father	Both		Mother	Father	Both	
○	○	○	Discussion and education	○	○	○	Positive reward and praise
○	○	○	Time-out	○	○	○	Spanking
○	○	○	Restriction/ grounding	○	○	○	Contract/ token systems
○	○	○	Nagging/ screaming	○	○	○	_____

10. For what is your child most frequently disciplined? _____

_____

_____

_____

11. What types of discipline work best with your child? _____

_____

_____

_____

12. Are there any "family secrets" or important things we have left out (include such things as relationship between divorced parents, involvement of extended family, parental adjustment difficulties, etc.)? ○ Yes ○ No

13. Is there any family history of medical, developmental, learning, emotional, mental health, psychiatric, or legal difficulties? ○ Yes ○ No

a. If yes, please list the individual's relationship to the child, the nature of the difficulty, and any treatments received. _____

_____

_____

14. Has this child or any sibling received any psychiatric or psychological treatment before? ○ Yes ○ No

a. If yes, please explain: _____

15. Is there a family history of heart disease, sudden death, suicide? ○ Yes ○ No

_____

BEHAVIOR SURVEY SECTION A

1. The following ratings best describe overall behavior during the past six months:

		Never	Some-times	Often	Very Often
a.	Fails to pay close attention to details or makes careless mistakes **(eg, overlooks or misses details, work is inaccurate).**	○	○	○	○
b.	Has difficulty paying attention to tasks or play activities **(eg, has difficulty remaining focused during lectures, conversations, or lengthy reading).**	○	○	○	○
c.	Does not seem to listen when spoken to directly **(eg, mind seems elsewhere, even in the absence of any obvious distraction).**	○	○	○	○
d.	Doesn't follow through on instructions or finish things **(eg, starts tasks but quickly loses focus and is easily sidetracked).**	○	○	○	○
e.	Has difficulty organizing tasks and activities **(eg, difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time managment; fails to meet deadlines).**	○	○	○	○
f.	Loses things necessary for tasks or activities **(eg, school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses).**	○	○	○	○
g.	Is easily distracted by extraneous stimuli **(for older adolescents and adults may include unrelated thoughts).**	○	○	○	○
h.	Is forgetful in daily activities or requires repetition **(eg, doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).**	○	○	○	○
i.	Avoids or dislikes tasks requiring sustained mental effort **(schoolwork, homework, etc.)**	○	○	○	○
j.	Often fidgets with or taps hands or feet or squirms in seat	○	○	○	○
k.	Often leaves seat when expected to remain seated **(eg, leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).**	○	○	○	○
l.	Often runs about or climbs on things in inappropriate situations **(Note: In adolescents or adults, may be limited to feeling restless.)**	○	○	○	○
m.	Often has difficulty playing or relaxing quietly	○	○	○	○
n.	Is "on the go" or seems if "driven by a motor" **(eg, is unable to be or uncomfortable being still for extended time, as in restaurants, Meetings; may be experienced by others as being restless or difficult to keep up with).**	○	○	○	○
o.	Often talks excessively	○	○	○	○
p.	Often blurts out answers before questions have been completed **(eg, ocmpletes people's sentences; cannot wait turn in conversation).**	○	○	○	○
q.	Often has difficulty waiting turn **(eg, shile waiting in line).**	○	○	○	○
r.	Often interrupts or intrudes on others **(eg, butts into conversations, games, or activities; may start using other peoples things Without asking or receiving permission; for adolescents and adults, may intrude into or Take over what others are doing).**	○	○	○	○
s.	Has trouble staying alert during the day	○	○	○	○
t.	Has trouble getting started on a task or prioritizing	○	○	○	○
u.	Acts impulsively and has poor planning/strategy techniques	○	○	○	○
v.	Demonstrates mental fatigue, boredom, or "laziness"	○	○	○	○
w.	Does things too slowly or quickly	○	○	○	○
x.	Demonstrates inconsistent concentration, effort, and/or behavior	○	○	○	○

2. Some of the above symptoms began before the age of 7 ○ Yes ○ No

3. The symptoms in this category are currently present ○ Yes ○ No

a. If yes, do they interfere with the child's social relationships? ○ Yes ○ No

b. If yes, do they interfere with schoolwork? ○ Yes ○ No

c. If yes, do they interfere with home functioning? ○ Yes ○ No

SECTION B

1. The following ratings best describe overall behavior during the past six months:

		Never	Some-times	Often	Very Often
a.	Loses temper	○	○	○	○
b.	Argues with adults	○	○	○	○
c.	Defies or refuses adult request's or rules	○	○	○	○
d.	Deliberately annoys others	○	○	○	○
e.	Is touchy or easily annoyed	○	○	○	○
f.	Is angry	○	○	○	○
g.	Is resentful and spiteful	○	○	○	○

2. The symptoms in this category are currently present ○ Yes ○ No

a. If yes, do they interfere with the child's social relationships? ○ Yes ○ No

b. If yes, do they interfere with schoolwork? ○ Yes ○ No

c. If yes, do they interfere with home functioning? ○ Yes ○ No

SECTION C

1. The following ratings best describe overall behavior during the past six months:

		Never	Some-times	Often	Very Often
a.	Bullies, threatens, or intimidates	○	○	○	○
b.	Starts physical fights	○	○	○	○
c.	Has used a weapon that could cause serious harm	○	○	○	○
d.	Has been physically cruel to people	○	○	○	○
e.	Has been physically cruel to animals	○	○	○	○
f.	Has stolen with confrontation	○	○	○	○

		Never	Some-times	Often	Very Often
h.	Has set fire(s) with the intention to cause damage	○	○	○	○
i.	Has otherwise deliberately destroyed property	○	○	○	○
j.	Has broken into someone's house, car, or building	○	○	○	○
k.	Lies to avoid obligations, such as conning others	○	○	○	○
l.	Has stolen when others are not looking	○	○	○	○

m. Has run away from caregiver's home at least twice ○ Yes ○ No

n. Has stayed out at night even though parents object ○ Yes ○ No

o. Has been truant from school ○ Yes ○ No

2. One or more of the above problems in this category began before age 10 ○ Yes ○ No

3. The behaviors in this category are currently present ○ Yes ○ No

a. If yes, do they interfere with the child's social relationships? ○ Yes ○ No

b. If yes, do they interfere with schoolwork? ○ Yes ○ No

c. If yes, do they interfere with home functioning? ○ Yes ○ No

SECTION D

1. The following ratings best describe overall behavior nearly every day during the past two weeks:

	Never	Some-times	Often	Very Often
a. Depressed	○	○	○	○
b. Diminished interest or pleasure in activities	○	○	○	○
c. Difficulty sleeping or sleeping too much	○	○	○	○
d. Restless or slowed down	○	○	○	○
e. Tired or without energy	○	○	○	○
f. Feels worthless or guilty	○	○	○	○
g. Decreased ability to think or concentrate, or difficulty making decisions, as reported by child/adolescent, or observed by others	○	○	○	○
h. Repeated thought of death or suicide, a suicide plan/attempt	○	○	○	○
i. Irritable mood that is continued and extreme	○	○	○	○
j. Views himself or herself as more important and more intelligent	○	○	○	○
k. Sleeps less than 3 hours a night	○	○	○	○
l. More talkative than appropriate	○	○	○	○
m. Often changes direction of conversation or states thought	○	○	○	○
n. Highly distracted by unimportant stimuli	○	○	○	○
o. Gets excessively involved in activities	○	○	○	○
p. Performs acts that knowingly result in negative consequences	○	○	○	○
q. Interest in sexual themes at an early ago	○ Yes		○ No	

2. Significant change in appetite and/or weight not due to dieting within the same <u>1 month</u> period, or not meeting the expected weight gain ○ Yes ○ No

3. The behaviors in this category are currently present ○ Yes ○ No

a. If yes, do they interfere with the child's social relationships? ○ Yes ○ No

b. If yes, do they interfere with schoolwork? ○ Yes ○ No

c. If yes, do they interfere with home functioning? ○ Yes ○ No

<u>SECTION E</u>

1. The following ratings best describes overall behavior during past 6 months:

	Never	Some-times	Often	Very Often
a. Excessively anxious and worried about a number of issues	○	○	○	○
b. Has difficulty controlling the worry	○	○	○	○
c. Restless, keyed up, or on edge	○	○	○	○
d. Easily tired	○	○	○	○
e. Difficulty concentrating or mind goes blank	○	○	○	○
f. Irritable	○	○	○	○
g. Muscle tension	○	○	○	○
h. Sleep disturbance	○	○	○	○
i. Excessive fear of any specific event or object	○	○	○	○

2. The behaviors in this category are currently present? ○ Yes ○ No

a. If yes, do they interfere with the child's social relationships? ○ Yes ○ No

b. If yes, do they interfere with schoolwork? ○ Yes ○ No

c. If yes, do they interfere with home functioning? ○ Yes ○ No

SECTION F

1. The following ratings best describes overall behavior during past 6 months:

	Never	Some-times	Often	Very Often
a. Unusually fearful of becoming embarrassed or humiliated in interactions with both other children and adults	○	○	○	○
b. Cries, tantrums, freezes, withdraws, or panics when exposed to a feared social situation	○	○	○	○
c. Tries to avoid a feared social situation or is very distressed in its presence	○	○	○	○

2. Anxiety, avoidance, or distress is currently present?	○ Yes	○ No
a. If yes, do they interfere with the child's relationships?	○ Yes	○ No
b. If yes, do they interfere with schoolwork?	○ Yes	○ No
c. If yes, do they interfere with home functioning?	○ Yes	○ No

SECTION G

1. Has your child been exposed to a traumatic, life-threatening event or experienced neglect or abuse of any kind?	○ Yes	○ No
a. If yes, has he or she experienced intense fear, helplessness, horror, agitation, or confusion due to the event?	○ Yes	○ No
b. If yes, does he or she repeatedly recall the event or incorporate it into play activities?	○ Yes	○ No
c. If yes, does he or she have repeated nightmares due to the event?	○ Yes	○ No
2. The concerns in this category are currently present?	○ Yes	○ No
a. If yes, do they interfere with the child's relationships?	○ Yes	○ No
b. If yes, do they interfere with schoolwork?	○ Yes	○ No
c. If yes, do they interfere with home functioning?	○ Yes	○ No

SECTION H

	Never	Some-times	Often	Very Often
1. Experiences recurrent worries, thoughts, or images that are difficult to ignore	○	○	○	○
2. Recurrent thoughts or images experienced cause distress or anxiety	○	○	○	○
3. The thoughts are more than worries about real life problems	○	○	○	○
4. Tries to ignore, replace, or suppress thoughts	○	○	○	○

5. The difficulties in this category are currently present	○ Yes	○ No
a. If yes, do they interfere with the child's relationships?	○ Yes	○ No
b. If yes, do they interfere with schoolwork?	○ Yes	○ No
c. If yes, do they interfere with home functioning?	○ Yes	○ No

SECTION I

	Never	Some-times	Often	Very Often
1. Does unusual movements for no apparent reason reason (eye blinking, twitching, lip licking, head jerking, etc.)	○	○	○	○
2. Makes vocal sounds for no apparent reason (coughing, throat clearing, sniffling, grunting, etc)	○	○	○	○

3. Both of above having a duration of more than one year	○ Yes	○ No

4.	**The difficulties in this category are currently present**	○ Yes	○ No
a.	If yes, do they interfere with the child's relationships?	○ Yes	○ No
b.	If yes, do they interfere with schoolwork?	○ Yes	○ No
c.	If yes, do they interfere with home functioning?	○ Yes	○ No

SECTION J

	Never	Some-times	Often	Very Often
1. Is unable to verbally communicate his/her needs	○	○	○	○
2. Is unable to nonverbally communicate his/her needs (eg, lack of eye contact, gestures, limited range of facial expressions, lack of social smile)	○	○	○	○
3. Does not ask questions	○	○	○	○
4. Does not answer questions	○	○	○	○
5. Is not responsive to his/her name	○	○	○	○
6. Is unable to understand simple instructions	○	○	○	○
7. Has unusual language understanding or usage	○	○	○	○
8. Talks in a strange way (repeats what others say; confuses words like "you" and "I"; uses odd words or phrases, etc.)	○	○	○	○
9. Speaks like an adult in tone or uses overly correct grammar (e.g. "little professor")	○	○	○	○
10. Has trouble understanding jokes, sarcasm, metaphors, etc.	○	○	○	○
11. Does not talk to other children	○	○	○	○
12. Avoids eye contact with others	○	○	○	○
13. Does not play or relate well with other children (eg, lack of interest in peers, no friendships that involve selectively and sharing)	○	○	○	○
14. Does not smile at others	○	○	○	○
15. Could be characterized as unfriendly	○	○	○	○
16. Responds with inappropriate emotions for the situation	○	○	○	○
17. Lacks common sense	○	○	○	○
18. Seems unaware that he/she is different than peers	○	○	○	○
19. Has difficulty making socially appropriate conversation	○	○	○	○
20. Has trouble starting or ending conversations	○	○	○	○
21. Inability to continue with a conversation (eg, lack of back and forth conversation, failure to initiate or respond to social interactions)	○	○	○	○
22. Seems to have little interest in what others say or find interesting	○	○	○	○
23. Has a peculiar way of relating to others (avoids eye contact, odd facial expressions or gestures, etc.)	○	○	○	○
24. Is uninterested in making friends at peer level	○	○	○	○
25. Is unaware or takes no interest in other people's feelings	○	○	○	○
26. Does not respect the personal space of others	○	○	○	○
27. Displays standoffish behavior to affection (e.g. stiffens or pulls	○	○	○	○
28. Does not enjoy meeting new people or experiencing new places	○	○	○	○
29. Has sensitivity to noise, light, and touch	○	○	○	○
30. Avoids certain textures (e.g. sticky)	○	○	○	○
31. Displays abnormal reactions to loud or unpredictable noises	○	○	○	○
32. Displays abnormal reactions to smells	○	○	○	○

	Never	Some-times	Often	Very Often
33. Certain lighting is bothersome to him/her	○	○	○	○
34. Hears sounds not heard by others	○	○	○	○
35. Generally speaking, he/she is a picky eater	○	○	○	○
36. Is a picky eater due to the texture, taste, or smell of food	○	○	○	○
37. Is a picky eater due to the color of food	○	○	○	○
38. Is a picky eater when food is prepared differently	○	○	○	○
39. Is a picky eater due to intestinal problems	○	○	○	○
40. Is a picky eater due to allergies	○	○	○	○
41. Prefers or insists to wear clothing of specific material	○	○	○	○
42. Has difficulty wearing tight clothing	○	○	○	○
43. Eats a healthy, balanced diet	○	○	○	○
44. Eats vegetables	○	○	○	○
45. Eats meat	○	○	○	○
46. Craves dairy products	○	○	○	○
47. Craves food rich in carbohydrates	○	○	○	○
48. Eats inedible objects	○	○	○	○
49. Gets very upset over small changes in routine or surroundings	○	○	○	○
50. Becomes anxious or panics when unplanned events occur	○	○	○	○
51. Becomes anxious or panics without obvious reason	○	○	○	○
52. Makes strange repetitive movements (flapping arms, etc.)	○	○	○	○
53. Has strange fascination for parts or objects (eg, sensory interest In a part of a toy, interested in the sight, feel, sound, taste, or smell of object)	○	○	○	○
54. Performs a behavior repeatedly or "obsessively	○	○	○	○
55. Displays behavior that is self-stimulatory	○	○	○	○
56. Enjoys spinning and/or swinging	○	○	○	○
57. Bites self	○	○	○	○
58. Bangs his/her head	○	○	○	○
59. Brings objects close to eyes in order to look at them	○	○	○	○
60. Covers his/her eyes with his/her hands or objects	○	○	○	○
61. Covers his/her ears with his/her hands	○	○	○	○
62. Displays an obsessive interest in a narrow subject	○	○	○	○
a. Imposes such interests on others	○	○	○	○
63. Displays superior ability in a narrow subject, while displaying average to above average ability in other subjects	○	○	○	○
64. Is unable to "pretend" or "make believe" when playing	○	○	○	○
65. Is unable to brush his/her teeth by him/herself	○	○	○	○
66. Is unable to wash his/her hands by him/herself	○	○	○	○
67. Is unable to comb his/her hair by him/herself	○	○	○	○
68. Is unable to use the toilet by him/herself	○	○	○	○

	Never	Some-times	Often	Very Often
69. Does not urinate in the toilet	○	○	○	○
70. Does not have bowel movements in the toilet	○	○	○	○
71. Does not use the proper utensils to eat	○	○	○	○
72. Is not cautious of approaching dangerous situations	○	○	○	○
73. Is unable to copy a straight line	○	○	○	○
74. Trips and falls	○	○	○	○
75. Is unable to jump over small objects without falling	○	○	○	○
76. Walks into things	○	○	○	○
77. Is unable to run with coordination	○	○	○	○
78. Is unable to jump up and down	○	○	○	○
79. Climbs with poor balance	○	○	○	○
80. Avoids climbing objects	○	○	○	○
81. Is unable to throw a ball	○	○	○	○
82. Is unable to catch a ball	○	○	○	○
83. Is destructive	○	○	○	○
84. Is hyperactive	○	○	○	○
85. It is difficult for him/her to remain seated through a meal	○	○	○	○
86. Is apathetic in most situations	○	○	○	○
87. Has difficulty getting to the point, loses train of thought	○	○	○	○
88. Has Bizarre ideas (e.g. odd fascinations, strange ideas, hallucinations), disoriented, confused, staring or "spacey"	○	○	○	○
89. Has incoherent speech (mumbles, words only he/she understands)	○	○	○	○
90. Does not adapt behavior to environment (e.g. outside voice inside)	○	○	○	○
91. Is difficult to satisfy- needs gratification/immediate rewards	○	○	○	○
92. Is insensitive to punishment and/or rewards	○	○	○	○
93. Is oversensitive to criticism	○	○	○	○
94. Is aggressive	○	○	○	○

95.	**The symptoms in this category are currently present**	○ Yes	○ No
a.	If yes, do they interfere with the child's relationships?	○ Yes	○ No
b.	If yes, do they interfere with schoolwork?	○ Yes	○ No
c.	If yes, do they interfere with home functioning?	○ Yes	○ No

Melmed Center
4848 E. Cactus Road, Suite 940
Scottsdale, AZ 85254
Tel: (480) 443-0050
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melmed center

Dear Teacher,

We appreciate the opportunity to work with you and share in successful care planning. Your input is invaluable to the Melmed Center's assessment of progress with the current treatment interventions.

Please complete the attached rating scales and questionnaires. If you have any other information you would like to share, please add the additional information on the forms or on a separate piece of paper.

Thank you very much for your feedback!

Please return these forms to the parent or feel free to fax them to the Melmed Center fax# 480-443-4018

4848 East Cactus Road, Suite #940, Scottsdale, AZ 85254 (480) 443-0050
www.melmedcenter.com

melmed center

NeuroDevelopmental and Sensory Modulatory Therapy

Treatment for…

*Sensory Processing disorders
*Oral motor and eating challenges
*Learning disorders including handwriting and reading difficulty
*Crossing of midline
*Hand/finger strengthening and coordination
*Gross motor skills acquisition
*Motor planning
*Spacial awareness and visual perceptual skills

A **child's** occupation is play, movement and exploration.

B **arriers** can interrupt the spontaneous evolution of these processes

C **onnection** with the treatment process reveals such barriers, redirects growth tendencies, and recaptures the child's strengths.

The Process…

We begin with an EVALUATION of your child's strengths and motor differences. Based on this, TREATMENT GOALS are developed followed by a TREATMENT PLAN. PARENT EDUCATION and a HOME THERAPY PROGRAM are important foundations in positive treatment.

Neurodevelopmental and Sensory Modulatory Therapy utilizes activities and exercises which involve familiar play items and games. Task analysis of each exercise and activity reveals the clinical motives behind the selection of any particular play tool or game. Self-care requires use of items directly related to the task.

It is our desire to assist you and your child in developing his/her optimal motor and functional abilities that would enable him/her to enthusiastically and energetically engage in peer-related play, learning, and social experiences. Melmed Center provides uniquely skilled, expertly individualized treatment to infants, children, adolescents, and adults.

Call for scheduling or with any questions!

10/11 Revision Occupational Therapy Services

4848 East Cactus Road, Suite #940 Scottsdale, AZ 85254 (480) 443-0050
WWW.melmedcenter.com

The Academic Behavior Checklist (ABC)

melmed center

Today's Date: _____

Student's Name: _____ Age: _____ Gender: M / F

Grade: ____ Teacher:_____ Subject: _____

Class Time: _____ How long have you known this student? _____

School name: _____ School Phone: _____ School Fax: _____

Please list any strengths this child has.

_____

_____

_____

In what areas do you think this child needs help?

_____

_____

_____

Does the child receive any special education services? Yes_____ No _____ Please Explain:

_____

_____

_____

Has testing been performed? Yes_____ No _____ What were the results?

_____

_____

_____

Is testing currently being considered? Yes_____ No _____

What have you tried in the classroom to help this student?

_____

_____

_____

Please circle the number that best describes this child's performance

Rating Code: 0 = **Above Average** 1= **Average 2= Problematic**

			Senses:
0	1	2	Vision
0	1	2	Hearing
0	1	2	Touch
			Attention:
0	1	2	Alertness
0	1	2	Distractibility
0	1	2	Focused attention
0	1	2	Length of attention span
			Perceptual:
0	1	2	Discrimination of sounds
0	1	2	Discrimination of shapes
0	1	2	Tactile defensiveness
0	1	2	Sequencing
0	1	2	Speed of processing input
			Memory:
0	1	2	Immediate
0	1	2	Short-term retrieval
0	1	2	Rote (by heart)
0	1	2	Long-term retrieval
0	1	2	Visual
0	1	2	Auditory
0	1	2	Motor Skills
			Conceptual:
0	1	2	Understands oral directions
0	1	2	Understands written instructions
0	1	2	Grasps abstract language concepts
0	1	2	Grasps visual-spatial concepts
0	1	2	Integration of sight and sound
0	1	2	Integration of sight and movement
0	1	2	Ability to change to another task
0	1	2	Ability to reason logically
			Motor:
0	1	2	Gross motor coordination
0	1	2	Fine motor coordination
0	1	2	Balance
0	1	2	Handwriting
0	1	2	Speech clarity
0	1	2	Speed of output

Please circle the number that best describes this child's performance

Rating Code: 0 = **Above Average** 1= **Average 2= Problematic**

			Classroom behavioral performance:
0	1	2	Motivation to do well
0	1	2	Ability to work without rewards
0	1	2	Participation in class discussions
0	1	2	Test taking
0	1	2	Study skills
0	1	2	Homework completion
0	1	2	Homework turned in
0	1	2	Homework quality
0	1	2	Frequent arguments
0	1	2	Self-Monitoring
0	1	2	Inappropriate seeking of attention
0	1	2	Excessive socializing
0	1	2	Sloppiness/messiness
0	1	2	Can't prioritize
0	1	2	Poor use of unstructured time
0	1	2	Spacing out
0	1	2	Not completing activities
0	1	2	Trouble getting started
0	1	2	Irritable
0	1	2	Cursing
0	1	2	Insecurity
0	1	2	Anxious/ Tense
0	1	2	Physical complaints
0	1	2	Frequent absences
0	1	2	Frequent tardiness
0	1	2	Following classroom rules
			Academic Performance:
0	1	2	Reading recognition
0	1	2	Reading comprehension
0	1	2	Spelling
0	1	2	Arithmetic concepts
0	1	2	Arithmetic calculation
0	1	2	Written expression
0	1	2	Oral expression
0	1	2	Listening comprehension
0	1	2	Copying from the blackboard
0	1	2	Science
0	1	2	Social studies
0	1	2	Languages
0	1	2	Art
0	1	2	Music
0	1	2	Physical education

Please circle the number that best describes this child's behavior

Rating Code: 0 = No Problem 1 = Occasional Concern 2 = Frequent Concern 3 = Very Often A Problem

				Symptoms
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 to engage in 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 have been completed
0	1	2	3	Has difficulty waiting in line
0	1	2	3	Interrupts or intrudes on others
0	1	2	3	Loses temper
0	1	2	3	Actively defies or refuses to comply with adult's rules
0	1	2	3	Is angry or resentful
0	1	2	3	Is spiteful and vindictive
0	1	2	3	Bullies, threatens, or intimidates others
0	1	2	3	Initiates physical fights
0	1	2	3	Lies to obtain goods for favors or to avoid obligations
0	1	2	3	Is physically cruel to people
0	1	2	3	Has stolen items of nontrivial value
0	1	2	3	Deliberately destroys others' property
0	1	2	3	Is fearful, anxious, or worried
0	1	2	3	Is self-conscious or easily embarrassed
0	1	2	3	Is afraid to try new things for fear of making mistakes
0	1	2	3	Feels worthless or inferior
0	1	2	3	Blames self for problems; feels guilty
0	1	2	3	Feels lonely, unwanted, or unloved
0	1	2	3	Is sad, unhappy, or depressed
				Self-Esteem and social skills
0	1	2	3	Self-confidence
0	1	2	3	Negative comments about self
0	1	2	3	Negative comments about others
0	1	2	3	Takes responsibility
0	1	2	3	Cooperates with peers
0	1	2	3	Cooperates with teachers
0	1	2	3	Accepted by peers
0	1	2	3	Popularity
0	1	2	3	Social isolation
0	1	2	3	Alienates peers
0	1	2	3	Physically aggressive
0	1	2	3	Verbally abusive
0	1	2	3	Shares possessions
0	1	2	3	Considerate of others