Name: FMP/SSN last four: DOB:

Appointment Date: Contact Number:

PEDIATRIC ADHD VISIT

Do you have specific concerns or questions about your child's ADHD today?_____

_____

********(Please complete information below: If filled out before, list only changes since the last visit.)********

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/ Allergies **Asthma** **ADHD** **Overweight** **Chronic ear infections** **Other:**		**Hay fever/Allergies** **Asthma** **Sudden death** **Heart attack <50** **Other:**	**Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** Does your child ever forget to take their medications? ❑ Yes ❑ No

Please list any known **allergies** your child has (drug, food, latex) _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑Yes ❑ No Is this visit **deployment** related? ❑Yes ❑ No

Are either of the child's parents on **PRP status?** ❑Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend: ❑ DOD school ❑ British school ❑ Home-school Grade? ____ ❑ Aftercare **Any Concerns?** ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Would you say your child's overall health is: ❑ Excellent / Very Good / Good ❑ Fair / Poor

Do you & your child feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No _____

Does your child had/have:

Racing heart? Yes/No Duration?_____
Chest pain? Yes/No Duration?_____
Fainting? Yes/No Duration?_____
Headache? Yes/No Duration?_____
Mood swings? Yes/No Duration?_____
Tics? Yes/No Duration?_____

Eating less? Yes/No Duration?_____
Weight loss? Yes/No Duration?_____
Abdominal pain? Yes/No Duration?_____
Trouble Falling Asleep? Yes/No Duration?_____
Sleep problems? Yes/No Duration?_____
Other _____

Poor/failing grades? Yes/No Duration?_____
Inattentive? Yes/No Duration?_____
Hyperactivity? Yes/No Duration?_____

Problems getting along with others? Yes/No Duration? __
Behavior problems in the classroom? Yes/No Duration? __

When was your child diagnosed with ADHD? _____

What age did your child start medications? _____

What other medications has your child tried, if applicable? _____

Has your child had any counseling? ❑ Yes ❑ No

Any other therapies (speech, physical, occupational)? ❑ Yes ❑ No. If yes please list _____

Does your child have an individualized educational plan (IEP) in place with the school? ❑ Yes ❑ No

Does your child have a history of heart problems? ❑ Yes ❑ No

Is there a family history of: Hypertrophic Cardiomyopathy? Y/N Arrhythmia? Y/N Long QT syndrome? Y/N

Wt		HR	
Ht		RR	
BMI/%		SpO2	
Temp		BP	

Pain: ❑ Yes ❑ No Location of Pain _____

Imm UTD per ASIMS: ❑ Yes ❑ No

Technician Signature:_____

HPI:

NE	Examination:	Normal	Abnormal
□	General:	□ Active/Alert/WN/WD/NAD	□
□	Head/Neck:	□ NCAT/non-tender/FROM	□
□	Eyes:	□ Clear, no injection, no D/C, PERRL, EOMI	□
□	R ear:	□ TM gray/mobile	□ Bulging/immobile/red
□	L ear:	□ TM gray/mobile	□ Bulging/immobile/red
□	Nose:	□ No congestion/discharge	□ Congested
□	Oropharynx:	□ Pink, moist, no lesions	□
□	Lungs:	□ CTAB, no retractions, nl WOB	□
□	CV:	□ RRR s Murmur, strong pulses, cap refill < 2 sec	□
□	Abd:	□ Soft, NT, no HSM, no masses, nl BS	□
□	Ext:	□ NL, FROM, nontender, no edema	□
□	Skin:	□ No rash	□
□	Lymph:	□ No adenopathy	□
□	Neuro:	□ Nl gait, CN II-XII intact, strength 5/5, sensory intact to touch, DTR 2+/2+	□
□	Psychological:	□ Nl mood and affect □ Hyperactive behavior □ Impulsive behavior	□
	Other PE findings:	□	□

ASSESSMENT:

PLAN:

Target Symptoms/Goals: 1.
2.
3.

F/U:

□ Patient and/or parent verbalizes understanding of treatment and plan

PREVENTION: ☐ Safety ☐ Tobacco avoidance ☐ Car Seat/Seatbelt ☐ Safe guard medications

☐ Nutrition ☐ Exercise ☐ Media Time

Signature:_____
Date:
Stamp:

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RECORDS MAINTAINED AT: ▶			
PATIENT'S NAME *(Last, First, Middle Initial)*			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

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