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Patient Evaluation – ADD/ADHD (Adult)

GENERAL INFORMATION

Name: _____ DOB: _____
Address: _____
Home Phone: _____ Work Phone: _____
Weight: _____ Height: _____
Sex: _____ Male _____ Female Email: _____
Referred By: _____

GOALS FOR THIS CONSULTATION

- 1.
- 2.
- 3.

MEDICAL STATUS

Current diagnosis or medical conditions: _____

Current medications: _____

Current vitamins or OTC products: _____

Current herbs/etc.: _____

Allergies (Drug/Food/Environmental): _____

LIFESTYLE

Do you get routine physical exercise: _____ What type: _____
_____ How often: _____
Do you use caffeine products: _____ How much: _____
Do you use alcohol: _____ How much and How often: _____
Do you use tobacco products: _____ How much: _____
Describe your typical, daily diet: _____

FAMILY HISTORY

Please list family members who have or have had important diseases such as high cholesterol, high blood pressure, heart disease, stroke, diabetes, etc.: _____

Do you:

- Have unusual fatigue unrelated to exertions?
- Feel chillier than others, often needing to wear socks to bed?
- Dress in layers because of needing to adjust to various temperatures?
- Have feelings of anxiety that sometimes lead to panic?
- Have trouble with weight, often eating lightly, yet still not losing a pound?
- Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- Have increased problems with digestion or allergies?
- Feel mentally sluggish, unfocused, or unusually forgetful?
- Know of anyone in your family who has ever had a thyroid problem?
- Suffer from dry skin, or are prone to adult acne or eczema?
- Go through periods of depression, and/or lowered sex drive?
- Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
- Experience your hair as feeling like straw, dry and easily falling out?
- Have significant menopausal symptoms or migraine despite estrogen?
- Have a history of whiplash or other neck injuries?
- Have a history of significant exposure to chlorine, bromine, or fluoride?
- Feel utterly exhausted by evening, yet have trouble sleeping?
- Wake up tired?

Within your family, is there a history of any of the following:

- Depressive Disorders
- Bipolar Disorders
- Anxiety Disorders
- Chemical and/or Behavioral Addictions
- Conduct Disorders
- Learning Disorders
- Developmental Disorders
- Obsessive/Compulsive Disorders
- Personality Disorders

Have you been diagnosed by a physician as having ADD or ADHD? _____

Diagnosing physician: _____

Date of diagnosis: _____

The items below refer to how you have behaved and felt DURING MOST OF YOUR ADULT LIFE. If you have usually been one way and recently have changed, your responses should reflect HOW YOU HAVE USUALLY BEEN. Circle one of the numbers that follows each item using the following scale:

0 = Not at all 1 = Just a little 2 = Somewhat 3 = Moderately 4 = Quite a lot 5 = Very much

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1. At home, work, or school, I find my mind wandering from tasks that are uninteresting or difficult. 0 1 2 3 4 5
 2. I find it difficult to read written material unless it is very interesting or very easy. 0 1 2 3 4 5
 3. Especially in groups, I find it hard to stay focused on what is being said in conversations. 0 1 2 3 4 5
 4. I have a quick temper...a short fuse. 0 1 2 3 4 5
 5. I am irritable, and get upset by minor annoyances. 0 1 2 3 4 5
 6. I say things without thinking, and later regret having said them. 0 1 2 3 4 5
 7. I make quick decisions without thinking enough about their possible bad results. 0 1 2 3 4 5
 8. My relationships with people are made difficult by my tendency to talk first and think later. 0 1 2 3 4 5
 9. My moods have highs and lows. 0 1 2 3 4 5
 10. I have trouble planning in what order to do a series of tasks or activities 0 1 2 3 4 5
 11. I easily become upset. 0 1 2 3 4 5
 12. I seem to be thin skinned and many things upset me. 0 1 2 3 4 5
 13. I almost always am on the go. 0 1 2 3 4 5
 14. I am more comfortable when moving than when sitting still. 0 1 2 3 4 5
 15. In conversations, I start to answer questions before the questions have been fully asked. 0 1 2 3 4 5
 16. I usually work on more than one project at a time, and fail to finish many of them 0 1 2 3 4 5
 17. There is a lot of "static" or "chatter" in my head. 0 1 2 3 4 5
 18. Even when sitting quietly, I am usually moving my hands or feet. 0 1 2 3 4 5
 19. In group activities it is hard for me to wait my turn. 0 1 2 3 4 5
 20. My mind gets so cluttered that it is hard for it to function. 0 1 2 3 4 5
 21. My thoughts bounce around as if my mind is a pinball machine. 0 1 2 3 4 5
 22. My brain feels as if it is a television set with all the channels going at once. 0 1 2 3 4 5
 23. I am unable to stop daydreaming. 0 1 2 3 4 5
 24. I am distressed by the disorganized way my brain works. 0 1 2 3 4 5

TOTAL _____

Are you currently under the care of a specialist? _____

Doctor: _____

What other medications/therapies have you tried to manage your ADD/ADHD? _____

Date: _____ Signature: _____

Since health information may change periodically, please notify your South River Compounding Pharmacy, Inc. pharmacist of any new medications (prescription and nonprescription), allergies, drug reactions or health conditions.

Your signature acknowledges your receipt of SRCP's Notice of Privacy Practices according to New Federal Government HIPAA Regulations (This notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your Protected Health Information.