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Patient Evaluation – ADD - Child

GENERAL INFORMATION

Name: _____ DOB: _____
Name of Parent or Guardian: _____
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

Does your child get routine physical exercise: _____ What type: _____

How often: _____
Does your child use caffeine products: _____ How much: _____
Describe your child's 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.: _____

Does your child:

- 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 is prone to acne or eczema?
- Go through periods of depression?
- Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
- Experience his/her hair as feeling like straw, dry and easily falling out?
- 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

Has your child been diagnosed by a physician as having ADD or ADHD? _____

Diagnosing physician: _____

Date of diagnosis: _____

Please rate the following symptoms regarding your child's behavior:

Key: 0 = never, 1 = occasionally, 2 = often, and 3 = daily

1. Fails to give attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils or books).	0	1	2	3
8. Is easily distracted by extraneous stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands and feet or squirms in seat.	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected.	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor".	0	1	2	3
15. Talks excessively.	0	1	2	3
16. Blurts out answer before questions have been completed.	0	1	2	3
17. Has difficulty waiting in line.	0	1	2	3
18. Interrupts or intrudes on others (e.g., butts into conversations or games).	0	1	2	3

Is your child currently under the care of a specialist? _____

Doctor: _____

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

Date: _____ Signature of Parent or Guardian: _____

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.