



## South River Compounding Pharmacy, Inc.

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### CHILD EVALUATION FOR CONSULTATION

The answers provided in the questions below will allow us to maintain your medical history and will help in advising about current medical therapies. All information will be kept confidential.

P A T I E N T  I N F O R M A T I O N	Date ___/___/___				
	Name _____		Date of Birth _____		Age _____ Sex _____
	Address _____ City/State/Zip _____				
	Parents _____				
	Home Ph _____		Cell Ph _____		Work Ph _____
	Email _____ (only used by SRCP and not sold to other entities)				
	Living Situation - Both Parents    Single Parent    Other _____				
	Siblings - _____				
	Pets _____				
	Drug allergies/Food allergies/Environmental allergies/Sensitivities _____				
	How did you hear about South River Compounding Pharmacy?				
	Advertisement	Courses/Seminars	Physician/Practitioner	Books/Magazines	Another Patient – who?

I N S U R A N C E	Insurance Company _____		ID# _____	
	Policy Holder _____		Group # _____	
	Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco ... We will need to obtain a copy of your insurance card.			

What are your goals for this consultation?

- 1.
- 2.
- 3.

**PAST MEDICAL CONDITIONS**

Childhood diseases: \_\_\_\_\_

**CURRENT MEDICAL STATUS**

Describe your child’s health \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_

Current diagnosis or medical conditions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Vitamins/Herbs/OTC: \_\_\_\_\_

**HABITS**

Please List a brief example of a typical day’s diet

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Dietary Restrictions \_\_\_\_\_

Does your child get routine physical exercise? \_\_\_ Type/Frequency \_\_\_\_\_

Does your child use caffeine products? Yes No How much \_\_\_\_\_

How much water does he/she drink daily? \_\_\_\_\_

**FAMILY HISTORY**

Indicate family members who are still living with these diseases

	History Heart Disease	History Cancer	History Osteoporosis	History Diabetes	Other
mother					
father					
sibling					
grandmother					
grandfather					

Indicate family members who died of these diseases

Family member	Age	Heart Disease	Cancer	Other – identify disease

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

**SYMPTOMS I** – Check the box if the statement applies to 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, 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?
- Is there 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, or early graying hair?
- Experience your hair as feeling like straw, dry and easily falling out?
- Have a history of headaches?
- Have 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?

**SYMPTOMS II** – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	<u>ABSENT</u>	<u>MILD</u>	<u>MODERATE</u>	<u>SEVERE</u>
Energy crashes mid-afternoon				
Fatigue, lack of energy				
Craving salty food				
Exhausted easily				
Sensitive to changes in weather				
Dark circles under eyes				
Wounds heal slowly				
Body tender/sensitive to touch				
Feel puffy/swollen all over				
Mind Racing at Bedtime				

Does your child complain or have symptoms of any of the following?

- Gas
- Bloating
- Reflux
- Yeast
- Antibiotic usage
- Diarrhea
- Constipation
- Cramps

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

If you would like us to share this information with your physician, please initial \_\_\_\_\_  
Please list the physician name and phone # \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Your signature acknowledges your understanding of SRCP's Notice of Privacy Practices according to HIPAA regulations. It does not acknowledge your agreement or any restrictions you may have requested regarding your Protected Health Information.