



## South River Compounding Pharmacy, Inc.

2300 Robious Station Circle  
 Midlothian, VA 23113  
 Fax: 804-897-6449  
 Phone: 804-897-6447  
[www.southriverrx.com](http://www.southriverrx.com)

3656 Mayland Court  
 Richmond, VA 23233  
 Fax: 804-967-6449  
 Toll Free 1-888-879-7713  
[scheduling@southriverrx.com](mailto:scheduling@southriverrx.com)

### CHILD FOLLOW-UP EVALUATION FORM 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 S U R A N C E	Date ___/___/___  Name _____ Date of Birth: _____ Age _____ Address if new _____ City/State/Zip _____ Home Ph _____ Cell Ph _____ Work Ph _____ Email _____ (only used by SRCP and not sold to other entities)  Your primary care MD is _____ Your Ob/Gyn is _____ Address _____ Address _____ Tel # _____ Tel # _____ ***** IS THERE A CHANGE IN YOUR INSURANCE?  Insurance Company _____ ID# _____ Policy Holder _____ Group # _____  Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco ... <b>We will need to obtain a copy of your insurance card.</b>
--	---

At this point in the program, my primary goals and/or chief concerns are:

- 1.
- 2.
- 3.

*(Check the answer that best describes you)*

I complied with the protocol/plan designed for me at the last visit and take my supplements and prescriptions as scheduled:

- Everyday                       75% of the time                       50% of the time                       25% of the time
- Rarely

What challenges or obstacles keep you from following your plan and taking your supplements and prescriptions as scheduled?

I feel that the protocol/plan I've been following has helped me improve:

- by 100%
- by 75%
- by 50%
- 25% or less
- no improvement

**NEW SYMPTOMS:**

- 1.
- 2.
- 3.
- 4.

**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? \_\_\_\_\_

What stressors in your child's life contribute to their current state of health?

**FAMILY HISTORY**

Please list any changes:

**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				
Difficulty Losing Weight				
Difficulty Falling Asleep				
Difficulty Staying Asleep				

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

- Gas
- Bloating
- Reflux
- Yeast
- Recent 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.