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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.

PATIENT INSURANCE

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 # _____

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IS THERE A CHANGE IN YOUR INSURANCE?

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.

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.

	ABSENT	MILD	MODERATE	SEVERE
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.	Interupts 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.

12/2011br