∞ Nature Cures Naturopathic Clinic ∞

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ADOLESCENT INTAKE FORM
12 Year Old or Older

Please write out behavioral concerns and bring with you to visit or email me so we need not discuss them in front of your child. (drcathypicard@yahoo.com)

Patient's Name:_____
Patient's e-mail:_____
Parent's Name:_____
Parent's e-mail:_____
Address:_____
City:_____ State:_____Zip Code:_____
Telephone:_____ Parent Work or Cell:_____
Age:_____Date of birth:_____Gender:_____
How did you hear about us?_____
Has any other family member been a patient at this clinic?_____
Child's primary care doctor:_____
Other practitioners involved in the care of your child:_____
_____
_____
Family members living at home with the patient:_____
Patient's school: _____
Emergency contact:_____Relationship:_____Phone: _____

CONTEXT OF CARE REVIEW
Why did you choose to come to this clinic?

What do you know about my approach to treatment?

What three expectations do you have for your first visit?

What are your long term expectations?

What potential obstacles may stand in the way of initiating the healing protocols we will be sharing with you?

What are the child's major health concerns?

Please list all current supplements, herbs, homeopathic remedies, and medications currently in use:
_____
_____
_____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE...THANK YOU

Has the child used the following currently or in the past? (please circle N for now, P for past)

Tylenol	N P	Decongestants	N P
Antibiotics	N P	Antihistamines	N P
Ibuprofen	N P	Other Medications: _____	

Allergies to medications:_____

MEDICAL HISTORY (Please check those that apply)

__Chicken Pox	__Scarlet Fever	__Tonsillitis
__Measles	__Pneumonia	__Ear Infection
__Mumps	__Frequent Colds	__Strep throat
__Rubella	__Rheumatic Fever	__Other (specify)

Has your child had any of the following? If so, when and what were the results?

EEG:_____
Psychological Evaluation:_____
Hearing Evaluation:_____
Speech/ Language Evaluation:_____

Please list injuries, surgeries and hospitalizations and their dates:
_____Date:_____
_____Date:_____
_____Date:_____

IMMUNIZATIONS (Please check those that apply)

__MMR	__DPT	__Chicken Pox	__Other
__Measels	__Diptheria	__Small Pox	__Mumps
__Tetanus	__Hepatitis B	__Polio	__Flu shot

Was your child (even mildly) ill at the time of administration?_____
Any adverse reactions?_____
Did any of the shots contain thimerosal?_____
Is your child on the schedule recommended by the CDC?_____

FAMILY HISTORY (Please check those that apply)

__Heart disease	__Diabetes	__Birth Defects
__High Blood Pressure	__Arthritis	__Tuberculosis
__Cancer	__Autoimmune Disease	__Allergy
__Asthma	__Mental Illness	__Osteopenia
__Addiction	__Stroke	__Kidney Disease
__Genetic Disorder	__Other (specify)_____	

PRENATAL HISTORY (check those that affected the mother during pregnancy/birth)

__High Blood Pressure	__Low Blood Pressure	__Physical Trauma
__Emotional Trauma	__Dental Fillings/Root canal	__Gestational Diabetes
__Prescription Drug Use	__Recreational Drugs	__Alcohol/cigarettes
__Toxic Exposure	__Hypothyroidism	__Induced labor
__Rhogam injection	__Cesarian delivery	__Iron deficiency
__Epidural	__Ptocin	__Vaginal Delivery
__Suction/forceps	__Rx. Medications (specify)_____	

Baby's weight at birth:_____ APGAR score_____
__Pre-mature __Late __Full Term

Please note conditions present shortly after birth:

__Rash	__Birth Injury	__Blue Baby
__Jaundice	__Seizures	__Cerebral Palsy
__Colic	__Fever	__Birth Defects
__Vomiting/reflux	__Formula fed (type:_____)	

__Breast Fed (length of time_____)
When were solids introduced?_____ What foods?_____
Were developmental milestones met?_____
Note child's age at the onset of the following: ____Sitting up ____Walking
____Crawling _____Babbling ____Talking

CURRENT HISTORY

Please describe your child's typical daily diet:
Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Beverages: _____

_____

Favorite Foods: _____

_____

For the following please circle **Y** for a condition you have now, **N** for something you've never had, or **P** for something that was a significant problem in the past.

HABITS

What are your main interests and hobbies?_____

_____

Do you exercise?	Y	N					
If yes, what kind?_____				How often?_____			
Get 6-8 hrs. of sleep?	Y	N		Enjoy your work?	Y	N	
Sleep well?	Y	N		Take Vacations?	Y	N	
Awaken rested?	Y	N		Spend time outside?	Y	N	
Have a supportive relationship?	Y	N		Watch television?	Y	N	
Have a history of abuse?	Y	N		How many hours?_____			
Any major traumas?	Y	N		Read?	Y	N	
Use recreational drugs?	Y	N	P	How many hours?_____			
Been treated for drug dependence?	Y	N	P	Do you eat three meals a day?	Y	N	
Use alcoholic beverages?	Y	N	P	Do you go on diets often?	Y	N	
Treated for alcoholism?	Y	N	P	Do you eat out often?	Y	N	
Do you use tobacco?	Y	N	P	Do you drink coffee?	Y	N	
Have you smoked previously?	Y	N		Drink black/green tea?	Y	N	
How many years?___				Drink cola or other soda?	Y	N	
How many packs per day?_____				Do you eat refined sugar?	Y	N	
				Do you add salt to food?	Y	N	

Do you have a religious or spiritual practice? If yes, what?_____

_____

REVIEW OF SYSTEMS

Please continue to answer the following questions in the same fashion, circle Y for a condition you have now, N for something you've never had, or P for something that was a significant problem in the past.

Mental/Emotional

Treated for emotional problems?	Y	N	P	Depression?	Y	N	P
Mood swings?	Y	N	P	Anxiety or nervousness	Y	N	P
Considered/attempted suicide?	Y	N	P	Tension?	Y	N	P
Poor concentration?	Y	N	P	Memory Problems?	Y	N	P

Immune

Reactions to immunizations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic Infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

Circle Y for a condition you have now, N for something you've never had, or P for something that was a significant problem in the past.

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness and tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema or hives?	Y N P
Acne or boils?	Y N P	Itching?	Y N P
Color changes?	Y N P	Perpetual hair loss?	Y N P
Lumps?	Y N P	Night sweats?	Y N P
		Warts?	Y N P

Head

Headaches?	Y N P	Head injury?	Y N P
Migraines?	Y N P	Jaw or TMJ problems?	Y N P

Eyes

Spots before your eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contact lenses?	Y N P
Blurriness?	Y N P	Eye pain or strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing in the ears?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Nose bleeds?	Y N P
Teeth grinding?	Y N P	Hay fever?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicking?	Y N P
Mercury fillings?	Y N P	Mouth sores or ulcers?	Y N P

Neck

Lumps in your neck?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Circle Y for a condition you have now, N for something you've never had, or P for something that was a significant problem in the past.

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing?	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain with breathing?	Y N P	Shortness of breath?	Y N P
Tuberculosis?	Y N P	Shortness of breath lying down?	Y N P

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low blood pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting?	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements:	
Gall bladder disease?	Y N P	How often_____	
Liver disease?	Y N P	Is this a change?	Y N
Hemorrhoids?	Y N P	Black or tar-like stool?	Y N P
Blood in stool?	Y N P	Parasites?	Y N P

Urinary

Pain with urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasm or cramps?	Y N P	Sciatica?	Y N P

Circulatory

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Circle Y for a condition you have now, N for something you've never had, or P for something that was a significant problem in the past.

Female Reproductive (if applicable)

Age at first menses?_____
Age at last menses (if menopausal)?_____
Length of cycle?_____days
Duration of menses?_____days
Painful menses? Y N P
Excessive or heavy flow? Y N P
PMS? Y N P
If yes, what are your symptoms?
_____
_____
Endometriosis? Y N P
Ovarian cysts? Y N P
Difficulty conceiving? Y N P
Abnormal PAP smear? Y N P
Sexual difficulties? Y N P
Gonorrhea? Y N P
Herpes? Y N P
Are you sexually active? Y N P
Do you do breast self-exams? Y N P
Breast pain or tenderness? Y N P

Date of last annual exam/PAP_____
Are cycles regular? Y N P
Bleeding between cycles? Y N P
Pain during intercourse? Y N P
Clotting during menses? Y N P
Vaginal discharge? Y N P
Birth control? Y N P
What type?_____
Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____
Menopausal symptoms? Y N P
Cervical dysplasia? Y N P
Chlamydia? Y N P
Condyloma (genital warts)? Y N P
Syphilis? Y N P
Sexual orientation?_____
Breast lumps? Y N P
Nipple discharge? Y N P

Male Reproductive (if applicable)

Hernias? Y N P
Testicular pain? Y N P
Venereal disease? Y N P
Are you sexually active? Y N P
Sexual orientation:_____
Impotence/erectile dysfunction? Y N P
Premature ejaculation? Y N P
Birth control/type?_____

Testicular masses? Y N P
Prostate disease? Y N P
Discharge or sores? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Condyloma (genital warts)? Y N P
Herpes? Y N P
Syphilis? Y N P

SYMPTOMS (Circle Y for a condition you have now, N for something you've never had, or P for something that was a significant problem in the past.)

Hives	Y N P	Pain with urination	Y N P	Blood in urine	Y N P
Eczema	Y N P	Cries easily	Y N P	Bleeding gums	Y N P
Heart murmur	Y N P	Anxious	Y N P	Nervous	Y N P
Acne	Y N P	Jaundice	Y N P	Nose Bleeds	Y N P
Vomiting	Y N P	Sleep problems	Y N P	Asthma	Y N P
Sensitive to light	Y N P	Chronic rash	Y N P	Stomach aches	Y N P
Diarrhea	Y N P	Constipation	Y N P	Hearing loss	Y N P
Easy bruising	Y N P	Sore Throats	Y N P	Flat feet	Y N P
Body/breath odor	Y N P	Poor or no appetite	Y N P	Nightmares	Y N P
Frequent Colds	Y N P	Easy bleeding	Y N P	Unusual or many fears	Y N P
Wheezing	Y N P	Cough	Y N P	Excessive Fatigue	Y N P
Joint Pain	Y N P	Dizzy spells	Y N P	Hair Loss	Y N P
Frequent urination	Y N P	Bed wetting	Y N P	Allergy (specify)_____	
Vision Problems	Y N P	Cold hands and feet	Y N P	Easy Bruising	Y N P
Chest pain	Y N P	Fainting	Y N P	Seizures	Y N P
Gas/flatulence	Y N P	Burping	Y N P	Teeth grinding	Y N P
Painful toileting	Y N P	Blood in stool	Y N P	Extreme thirst	Y N P

Weight:_____Height:_____
Does your child enjoy school?_____
Interests and hobbies:_____
Exercise: What type and how often?_____
T.V. (hours per week)_____
Time outside (hours per week)_____
Does your child sleep well?_____
Does your child wake feeling rested?_____

Please note any remaining thoughts or pertinent information below

_____
_____
_____
_____

I attest that the above information is complete and true to the best of my knowledge.

Parent or Guardian's signature:_____Date:_____

Thank you for taking the time to fill out this form thoughtfully and completely. I look forward to helping your child in any way I can.