**Nature Cures Naturopathic Clinic**
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## CONFIDENTIAL PATIENT INTAKE INFORMATION

Please take the time to complete this questionnaire thoroughly, as it will provide valuable information necessary for Dr. Picard to fully understand your current state of health.

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone # (home):_____ (cell):_____(work):_____

E-mail address:_____

Age:_____ Date of birth:_____ Gender:_____

Education:_____

Are you: Married____Separated____Divorced____Widowed____Single____Partnered____

Living with: Spouse____Partner____Parents____Children____Friends____Alone____

Occupation:_____ Hours per week:_____ Retired:_____

Employer:_____

Work Address:_____

How did you hear about Dr. Picard? _____

Has any other family member already been a patient at the clinic? _____

Emergency Contact:_____

Relationship:_____ Phone:_____

Address:_____

## CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient on a physical, mental and emotional level. The nature of your responses to the following questions will go a long way in assisting my understanding of your true desires for your health care. Your thoughtfulness and honesty in completing this overview will greatly assist me in providing the best care possible to suit your needs.

1) Why did you choose to come to this clinic?

   What do you know about my approach to treatment?

2) What three expectations do you have from your initial visit?

   What long term expectations do you have from working with Dr. Picard?

   What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (rate from 0 to 10, with 10 being 100% committed)
   0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

   What behaviors or lifestyle habits do you currently engage in regularly that you believe are detrimental to your health or self-destructive? (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

**ELEMENTS OF LIFE BALANCE**

Many factors within a person's life can affect their wellness. Please rate the following aspects of your life on a scale of 0-10. This rating should reflect your satisfaction with these areas of your life with 0 being complete dissatisfaction and 10 being completely happy.

Physical Environment____ Family and Friends____ Career____ Money____ Health____

Fun & Recreation____ Significant Other/Romance____ Personal Growth____

Are you currently receiving health care? Y N

If Yes, where and from whom? _____

_____

_____

If no, when did you last receive medical or health care? _____

_____

What was the reason?_____

_____

What are your most important health concerns? Please list as many as you can, in order of importance.

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

Do you have any known contagious diseases at this time? Y N

If yes, what?_____

**FAMILY HISTORY**

Do you have a family history of any of the following diseases? Please circle the ones that apply.

| | | | |
|---|---|---|---|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma | Hay fever/Hives | Auto-Immune Disease | |

Any other relevant family history?_____

_____

What is your heritage/ethnicity?_____

**CHILDHOOD ILLNESSES**

Please circle any of the following that you had as a child:

| | | | |
|---|---|---|---|
| Scarlet Fever | Mumps | Diphtheria | Rheumatic Fever |
| Measles | German Measles | Other_____ | |

**HOSPITALIZATION, SURGERY, IMAGING**

What hospitalizations, surgeries, X-rays, CAT Scans, EEG, EKG's have you had and when?

_____year:_____ _____year:_____

_____year:_____ _____year:_____

_____year:_____ _____year:_____

**ALLERGIES**

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Chemicals? _____

Environmental elements?_____

**CURRENT MEDICATIONS**

Do you take or use?

| | | | | | |
|---|---|---|---|---|---|
| Laxatives | Y N | Pain relievers | Y N | Antacids | Y N |
| Cortisone | Y N | Appetite suppressants | Y N | Antibiotics | Y N |
| Tranquilizers | Y N | Thyroid Medication | Y N | Sleep Aids | Y N |

Please list any prescription medication, over the counter medication, vitamins or other supplements you are taking?

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

**GENERAL**

Height:_____ Weight:_____lbs. Weight 1 yr. ago_____lbs.

Maximum weight:_____ When were you at your maximum_____

When during the day is your energy the best?_____ worst?_____

**TYPICAL FOOD INTAKE**

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

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 |

**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 |

**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 |

**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 |

**Female Reproductive**

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**

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

**If there is any other pertinent information, please add that in the space below.**

Thank you for your time and effort. I look forward to providing you with the best possible care.