ꕥ Nature Cures Naturopathic Clinic ꕥ
Dr. Cathy Picard, Naturopathic Physician
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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:____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE….THANKS

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.

5-36.1-3. Scope of practice.
15 (a) A license authorizes a licensee, consistent with naturopathic education and training 16 and competence demonstrated by passing the doctor of naturopathy licensing examination, to: 17 (1) Order and perform physical and laboratory examinations for diagnostic purposes; 18 (2) Dispense or order natural substances of mineral, animal, or botanical origin, including 19 food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and 20 their extracts, botanical substances, homeopathic substances, and all dietary supplements and 21 nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act that use various 22 routes of administration, including oral, nasal, auricular, ocular, rectal, vaginal, transdermal; 23 (3) Administer natural substances of mineral, animal, or botanical origin, including food, 24 extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their 25 extracts, botanical substances, homeopathic substances, and all dietary supplements and 26 nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act using transdermal 27 routes of administration; 28 (4) Administer or perform hot or cold hydrotherapy, electromagnetic energy, and 29 therapeutic exercise for the purpose of providing basic therapeutic care services, except that if a 30 referral to another licensed provider is appropriate for ongoing rehabilitation or habilitation 31 services, the doctor of naturopathy shall make the referral; 32 (5) Provide health education and health counseling; and 33 (6) Perform naturopathic musculoskeletal mobilization. 34 (b) If a doctor of naturopathy is engaged in the private practice of naturopathy in the LC001505/SUB A - Page 3 of 10 1 state, the doctor of naturopathy shall display the license obtained pursuant to this section 2 conspicuously in each office where the doctor of naturopathy is engaged in practice.

Cathy Picard, ND has a consultation agreement in accordance with the law with John Strauss, MD License # MD10393.

Patient Name (please print):______________________________Date:_____________

Signature of patient or legal guardian:____