Nature Cures Naturopathic Clinic
Dr. Cathy Picard, Naturopathic Physician
250 Eddie Dowling Hwy., N.Smithfield, RI 02896
Phone: 401-597-0477 Fax: 401-597-0959
www.drcathypicard.com

PEDIATRIC INTAKE FORM

Patient's Name:_____
Parent's Names:_____
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:_____

SYMPTOMS (Please indicate with "N" for symptoms your child has now and "P" for symptoms that your child has had in the past)

__Hives	__Pain with urination	__Blood in urine
__Eczema	__Cries easily	__Bleeding gums
__Heart murmur	__Anxious	__Nervous
__Acne	__Jaundice	__Nose Bleeds
__Vomiting	__Sleep problems	__Asthma
__Sensitive to light	__Chronic rash	__Stomach aches
__Diarrhea	__Constipation	__Hearing loss
__Easy bruising	__Sore Throats	__Flat feet
__Body/breath odor	__Poor or no appetite	__Nightmares
__Frequent Colds	__Easy bleeding	__Unusual or many fears
__Wheezing	__Cough	__Excessive Fatigue
__Joint Pain	__Dizzy spells	__Hair Loss
__Frequent urination	__Bed wetting	__Allergy (specify)_____
__Vision Problems	__Cold hands and feet	__Easy Bruising
__Chest pain	__Fainting	__Seizures
__Gas/flatulence	__Burping	__Teeth grinding
__Painful toileting	__Blood in stool	__Extreme thirst

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 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)

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.