

**∞ Nature Cures Naturopathic Clinic ∞**

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[www.drcathypicard.com](http://www.drcathypicard.com)

**PEDIATRIC INTAKE FORM  
11 Year Old or Younger**

**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: \_\_\_\_\_

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)

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Mumps	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Rubella	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> 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)

<input type="checkbox"/> MMR	<input type="checkbox"/> DPT	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Other
<input type="checkbox"/> Measles	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Mumps
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Polio	<input type="checkbox"/> 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)

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Birth Defects
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Addiction	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Other (specify)	_____

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Low Blood Pressure             | <input type="checkbox"/> Physical Trauma      |
| <input type="checkbox"/> Emotional Trauma      | <input type="checkbox"/> Dental Fillings/Root canal     | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Prescription Drug Use | <input type="checkbox"/> Recreational Drugs             | <input type="checkbox"/> Alcohol/cigarettes   |
| <input type="checkbox"/> Toxic Exposure        | <input type="checkbox"/> Hypothyroidism                 | <input type="checkbox"/> Induced labor        |
| <input type="checkbox"/> Rhogam injection      | <input type="checkbox"/> Cesarean delivery              | <input type="checkbox"/> Iron deficiency      |
| <input type="checkbox"/> Epidural              | <input type="checkbox"/> Ptoicin                        | <input type="checkbox"/> Vaginal Delivery     |
| <input type="checkbox"/> Suction/forceps       | <input type="checkbox"/> Rx. Medications (specify)_____ |   |

Baby's weight at birth: \_\_\_\_\_ APGAR score \_\_\_\_\_  
 Pre-mature                       Late                       Full Term

Please note conditions present shortly after birth:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Rash                              | <input type="checkbox"/> Birth Injury              | <input type="checkbox"/> Blue Baby      |
| <input type="checkbox"/> Jaundice                          | <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Colic                             | <input type="checkbox"/> Fever                     | <input type="checkbox"/> Birth Defects  |
| <input type="checkbox"/> Vomiting/reflux                   | <input type="checkbox"/> Formula fed (type: _____) |   |
| <input type="checkbox"/> 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)

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

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. ([drathypicard@yahoo.com](mailto:drathypicard@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.