ꕥ Nature Cures Naturopathic Clinic ꕥ
Dr. Cathy Picard, Naturopathic Physician
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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)

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

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:_____