
 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.drcahyopicard.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. (drcahyopicard@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"/> Diptheria	<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. (drcahy-picard@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.

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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: _____