

**ADOLESCENT INTAKE FORM
12 Year Old or Older**

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: _____

Patient's e-mail: _____

Parent's Name: _____

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"/> Measels | <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: _____

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 |

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.

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 |
| | | Warts? | 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 |

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.

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 |

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.

Female Reproductive (if applicable)

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 (if applicable)

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

SYMPTOMS (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.)

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

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 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.

 Nature Cures Naturopathic Clinic 

Dr. Cathy Picard, Naturopathic Physician
Phone: 401-597-0477 Fax: 401-597-0959
www.dr.cathypicard.com

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: _____