ꕥ Nature Cures Naturopathic Clinic ꕥ
Dr. Cathy Picard, Naturopathic Physician
Phone: 401-597-0477 Fax: 401-597-0959
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)

__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
__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. (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.

ENVIRONMENTAL HISTORY: For all of the questions below, most are often asked about the child's primary residence. Although some questions may specify certain locations, one should always consider all places where the child spends time, such as daycare centers, schools, and relative's houses.

Where does your child live and spend most of his/her time? ______________________

What are the age, condition, and location of your home? ______________________

Does anyone in the family smoke? Yes ☐ No ☐ Not sure ☐

Do you have a carbon monoxide detector? Yes ☐ No ☐ Not sure ☐

Do you have any indoor furry pets? Yes ☐ No ☐ Not sure ☐

What type of heating/air system does your home have? ______________________

What is the source of your drinking water? Well water ☐ City water ☐ Bottled water ☐

Is your child protected from excessive sun exposure? Yes ☐ No ☐ Not sure ☐

Is your child exposed to any toxic chemicals of which you are aware? Yes ☐ No ☐ Not sure ☐

What are the occupations of all adults in the household? ______________________

Have you tested your home for radon? Yes ☐ No ☐ Not sure ☐

Does your child watch TV, or use a computer or video game system more than two hours a day? Yes ☐ No ☐ Not sure ☐

How many times a week does your child have unstructured, free play outside for at least 30 minutes? ______________________

Do you have any other questions about your child's home environment or symptoms that may be a result of his/her environment? ______________________

Do you own or rent your home? ______________________

What year was your home built? (Or: was your home built before 1978? 1950?) ______________________

Has your child been tested for lead? Yes ☐ No ☐ Not sure ☐

Is there a family member or playmate with an elevated blood lead level? Yes ☐ No ☐ Not sure ☐

Does your child spend significant time at another location? (e.g. baby sitters, school, daycare?) ______________________

If a family member smokes, does this person want to quit smoking? Yes ☐ No ☐ Not sure ☐

Is your child exposed to smoke at the baby sitters, school, or daycare center? Yes ☐ No ☐ Not sure ☐

Do regular visitors to your home smoke? Yes ☐ No ☐ Not sure ☐

Have there been renovations or new carpet or furniture in the home during the past year? Yes ☐ No ☐ Not sure ☐

Does your home have carpet? Yes ☐ No ☐ Not sure ☐

Is the room where your child sleeps carpeted? Yes ☐ No ☐ Not sure ☐

Do you use a wood stove or fire place? Yes ☐ No ☐ Not sure ☐

Have you had water damage, leaks, or a flood in your home? Yes ☐ No ☐ Not sure ☐

Do you see cockroaches in your home daily or weekly? Yes ☐ No ☐ Not sure ☐

Do you see rats and/or mice in your home weekly? Yes ☐ No ☐ Not sure ☐

Do you have smoke detectors in your home? Yes ☐ No ☐ Not sure ☐

Is your home near an industrial site, hazardous waste site, or landfill? Yes ☐ No ☐ Not sure ☐

Is your home near major highways or other high traffic roads? Yes ☐ No ☐ Not sure ☐

Are you aware of Air Quality Alerts in your community? Yes ☐ No ☐ Not sure ☐

Do you change your child's activity when an Air Quality Alert is issued? Yes ☐ No ☐ Not sure ☐

Do you live on or near a farm where pesticides are used frequently? Yes ☐ No ☐ Not sure ☐

If you use well water for drinking, when was the last time the water was tested?

Coliform bacteria _____ Other microbials _____ Nitrites/nitrates _____ Arsenic _____ Pesticides _____

For all types of water sources:

- Have you tested your water for lead? Yes ☐ No ☐ Not sure ☐
- Do you mix infant formula with tap water? Yes ☐ No ☐ Not sure ☐

Which types of seafood do you normally eat? ______________________________

How many times per month do you eat that particular fish or shellfish? ______________________________

How many times a week do you eat any of the following types of fish?

Shark _____ Swordfish _____ Tile Fish _____ King Mackerel _____ Albacore Tuna_____ Other _____

How often do you wash fruits and vegetables before giving them to your child? ______________________________

What type of produce do you buy?

Organic ☐ Local ☐ Grocery store ☐ Other ☐

How often are pesticides applied inside your home? ______________________

How often are pesticides applied outside your home? ______________________

Where do you store chemicals/pesticides? ______________________

Do you often use solvents or other cleaning or disinfectant chemicals? ______________________

Do you have a deck or play structure made from pressure treated wood? Yes ☐ No ☐ Not sure ☐

Have you applied a sealant to the wood in the past year? Yes ☐ No ☐ Not sure ☐

What do you use to prevent mosquito bites to your children? ______________________

How often do you apply that products? ______________________

What type of hobbies does your child do? ______________________

Do any adults work around toxic chemicals? Yes ☐ No ☐ Not sure ☐

If so, do they shower and change clothes before returning home from work? Yes ☐ No ☐ Not sure ☐

Does the child or any family member have arts, crafts, ceramics, stained glass work or similar hobbies? Yes ☐ No ☐ Not sure ☐

Have you ever relocated due to concerns about an environmental exposure? Yes ☐ No ☐ Not sure ☐

Do symptoms seem to occur at the same time of day? Yes ☐ No ☐ Not sure ☐

Do symptoms seem to occur after being at the same place every day? Yes ☐ No ☐ Not sure ☐

Do symptoms seem to occur during a certain season? Yes ☐ No ☐ Not sure ☐

Are family members/neighbors/co-workers experiencing similar symptoms? Yes ☐ No ☐ Not sure ☐

Are there environmental concerns in your neighborhood, child's school, or day care? Yes ☐ No ☐ Not sure ☐

Has any family member had a diagnosis of any of the following?
Asthma ☐ Autism ☐ Cancer ☐ Learning Disability ☐

Does you child suffer from any of the following recurrent symptoms?
Cough ☐ Headaches ☐ Fatigue ☐ Unexplained pain ☐

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:____