
 Nature Cures Naturopathic Clinic 

Dr. Cathy Picard, Naturopathic Physician  
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Phone: 401-597-0477 Fax: 401-597-0959  
[www.drathypicard.com](http://www.drathypicard.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. (drathypicard@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.

**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 microbes \_\_\_\_\_ 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 your child suffer from any of the following recurrent symptoms?  
Cough  Headaches  Fatigue  Unexplained pain

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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: \_\_\_\_\_