Maggie Thibodeau, ND
CARY HOLISTIC HEALTH, LLC
222 Ashville Avenue, Suite 10 / Cary, NC 27518
(919) 858-1004 / CaryHolisticHealth.com

Thank you for scheduling an appointment with Cary Holistic Health.

We are located at 222 Ashville Avenue, Suite 10 – we share this suite with a busy family medical practice, as well as an aesthetics practice. Please let the front desk know you have arrived. If you have an appointment scheduled over the lunch hour, the front desk may be closed. Make yourself comfortable in the waiting area and Dr. Thibodeau will get you at your scheduled appointment time.

Please note that we are a fragrance-free facility – please refrain from wearing any perfumes, colognes or scented body lotions on the day of your appointment.

Plan to spend 1 – 1½ hours for your initial intake.
Please set aside some time prior to your initial visit to print and complete the forms included in this package and bring them with you to your first appointment:

- Consent to Treat form
- Financial Policy/Email Policy
- Adult Intake form

It is also extremely helpful to **bring any recent blood work or imaging results with you.**
If necessary, you can download the Authorization to Receive Medical Records form to deliver or fax to your doctor to have them send records directly to our office. There is a link on our website on the New Patients page.

Please bring any vitamins and supplements you are taking with you.

The fee for an initial appointment is $180. Follow-up appointments are usually 45 minutes, with a fee of $90. Fees can be paid by cash, check or Visa/MasterCard.

If you are unable to keep your scheduled appointment time, please give at least 48 hours notice so that we may allow other patients to have that appointment time.

We look forward to working with you towards your health and well-being!

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***Please bring all of the completed forms in this package with you to your first visit.**

ADULT INTAKE FORM

Name _____ Date of 1st Visit _____
Date of Birth _____ Age _____ Gender: M F
Address _____
City _____ State _____ Zip _____
Phone (home) _____ (work) _____ (cell) _____
E-mail _____ Would you like to receive our e-newsletter? Y N
If we need to contact you, messages can be left at (circle all that apply): Work Home Cell Email
Employer _____ Occupation _____ Hours per week _____
Marital Status: ____ Married ____ Separated ____ Divorced ____ Widowed ____ Single ____ Partnership
Number of Children: _____ Ages: _____ Sexes: _____
Live with: ____ Spouse ____ Partner ____ Parents ____ Children ____ Friends ____ Alone
How did you hear about our clinic? _____
Has any other family member been a client at this clinic? _____
Have you received naturopathic treatment in the past? _____

EMERGENCY CONTACT

Name _____ Phone: _____
Relationship _____ Address _____

HEALTHCARE PROVIDERS

Primary Health Care Physician: _____ Phone: _____
When was your last physical exam? _____
Are you currently under the care of a specialist? _____
Name: _____ Specialty: _____ Phone: _____
Name: _____ Specialty: _____ Phone: _____

List your primary health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you experienced any traumatic life events that you feel may be associated with any of your health concerns?

_____

_____

PERSONAL OVERVIEW

1. Improving health by addressing underlying imbalances often requires a commitment to lifestyle change and willingness to follow therapeutic protocols. How would you describe your present level of commitment? Rate on a scale from 1 to 10, with 10 indicating 100% commitment. (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

2. Are there any potential obstacles you foresee in addressing the lifestyle factors that are undermining your health or in adhering to the therapeutic protocols that I will be sharing with you?

3. What expectations do you have of me personally as your Naturopathic physician?

HEALTH HISTORY

How would you describe your current state of health? Excellent Good Fair Poor

Are you currently being treated for a health care concern by other healthcare practitioners? Please explain.

Do you have any known contagious diseases at this time? Y N If yes, what?

List any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have experienced, along with the approximate date.

	Date		Date

List any X-rays, CT scans, blood work or other studies that you have had, along with the approximate date.

Study	Date	Study	Date

Has there been an event or illness from which you have never fully recovered?

MEDICATIONS

Do you regularly use any of the following?

Laxatives Pain Relievers Antacids Sleeping Pills Birth Control Pills

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued.

Did you receive antibiotics frequently as a child? _____

Have you ever taken antibiotics for an extended period of time? _____

How many times have you received antibiotics in the past five years? _____

Please list all known allergies (food, environmental, medications):

_____

_____

Have you ever had an anaphylactic reaction? _____

Which vaccinations have you had?

HBV (hepatitis B) ___ Hepatitis A ___ Meningococcal ___ Other: _____

MMR (measles, mumps, rubella) ___ Tetanus Booster ___ Smallpox ___

Hib (Haemophilus influenza b) ___ Polio ___ Typhus ___

DPT (diphtheria, tetanus, pertussis) ___ VZV (chicken pox) ___ Influenza (flu shot) ___

Adverse Reactions

Please describe any adverse reactions, allergies, or sensitivities you have experienced with prescription or over-the-counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction

Illnesses

Please indicate if you've had any of the following illnesses:

Scarlet fever _____ Diphtheria _____ Rheumatic fever _____ Mumps _____ Measles _____

German measles _____ Chicken pox _____ Shingles _____ Tuberculosis _____

Medical History

	Father	Mother	Grandparents	Brothers	Sisters	Spouse	Child
Age (if living)							
Age when died							
Reason for death							

	Father	Mother	Grandparents	Brothers	Sisters	Spouse	Child
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/ Stroke	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Asthma / Allergies	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Melitus	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Do you have a family history that includes any of the following? (Please circle all that apply)

Cancer Cardiovascular Disease Alcoholism/Addiction Depression Diabetes Thyroid Disorder

Nutrition & Lifestyle

Food	#/wk	Food	#/wk	Food	#/wk
Fruits		Soy products (tofu, soy milk, etc.)		Fast food	
Vegetables		Soft drink (regular)		Coffee	
Luncheon meat/smoked meat		Soft drink (diet)		Regular (caffeinated) tea	
Breads and baked goods		Salty snack foods (chips, etc.)		Herbal tea/green tea	
Cow's milk		Sweets (candies, cookies, etc.)		Wine/beer	
Cheese		Artificial sweeteners		Other alcoholic drinks	
Yogurt		Meal replacement bars/drinks		Glasses of water/day?	

Is there anything about your diet you would like to change? _____

_____

On average how many meals do you have per day? 1 2 3 4 5 5+

List any foods that you crave regularly _____

List any foods you exclude from your diet _____

Do you follow a specific diet regime? Vegetarian ____ Vegan ____ Other _____

Any known food allergies/intolerances/sensitivities? _____

_____

Do you exercise? Y N What type and how often? _____

Do you spend time outdoors? How much? _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe. _____

_____

How would you describe the emotional climate of your home? _____

_____

How would you rate your stress level? Low 1 2 3 4 5 6 7 8 9 10 High

How well do you handle these stressors? _____

_____

Please list the 5 most significant stressful events in your life, from most recent to most distant (include date):

1. _____
2. _____
3. _____
4. _____
5. _____

How would you rate your energy? Low 1 2 3 4 5 6 7 8 9 10 High

Has you energy level changed recently? _____

Has your weight changed by more than 10lbs in the past 6 months? _____

Sleep

How many ours of sleep do you typically get? _____

Do you fall asleep easily and sleep soundly? _____

Do you feel refreshed on waking? _____

Do you have a regular sleep routine? _____

Medical History

Please indicate whether you experience, or have experienced in the past, any of the following.

Y = current concern **N** = never experienced **P** = experienced in past

Skin

Eczema, hives?	Y N P	Lumps?	Y N P
Acne, boils?	Y N P	Hair loss?	Y N P
Itching?	Y N P	Dryness?	Y N P
Colour change?	Y N P	Night sweats?	Y N P
Temperature change?	Y N P	Change in a mole?	Y N P

Head/Neck

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P
Goiter?	Y N P	Swollen glands?	Y N P
Glasses/contacts?	Y N P	Changes in vision?	Y N P
Eye pain?	Y N P	Colour blindness?	Y N P
Tearing or dryness?	Y N P	Cataracts?	Y N P
Glaucoma?	Y N P	Blind spot?	Y N P
Eyes sensitive to the sun?	Y N P	Ringing in ears?	Y N P
Eye itching/redness? Discharge?	Y N P	Impaired hearing?	Y N P
Sinus problems? Stuffiness?	Y N P	Earaches?	Y N P
Frequent sore throat?	Y N P	Ear discharge?	Y N P
Teeth grinding?	Y N P	Ear infections?	Y N P
Gum problems?	Y N P	Nose bleeds?	Y N P
Amalgam fillings?	Y N P	Hay fever?	Y N P
Loss of taste?	Y N P	Loss of smell?	Y N P
Sore tongue/mouth?	Y N P	Hoarseness?	Y N P
Jaw clicks?	Y N P		

Respiratory

Cough?	Y N P	Pain on breathing?	Y N P
Spitting up blood?	Y N P	Sputum?	Y N P
Asthma?	Y N P	Wheezing?	Y N P
Pneumonia?	Y N P	Bronchitis?	Y N P
Emphysema?	Y N P	Shortness of breath?	Y N P
Tuberculosis?	Y N P	Shortness of breath lying down?	Y N P

Cardiovascular

High blood pressure?	Y N P	Angina?	Y N P
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	Past ECG (Echocardiogram)?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Heartburn/ Indigestion?	Y N P
Vomiting blood?	Y N P	Constipation?	Y N P
Blood in stool?	Y N P	Diarrhea?	Y N P
Abdominal pain or cramps?	Y N P	Worms/Parasites?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/gall stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Bowel movements – how often?		Change in bowel movements?	Y N P

Urinary

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Inability to hold urine?	Y N P
Urination at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

Male Reproduction

Hernias?	Y N P	Prostate enlargement or disease?	Y N P
Testicular pain or masses?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Impotence?	Y N P	Gonorrhea?	Y N P
Premature ejaculation?	Y N P	Condyloma (i.e. genital warts)?	Y N P
Do you use birth control?	Y N P	Herpes?	Y N P
What type?	Y N P	Syphilis?	Y N P

Female Reproduction/Breasts

Age at first menses?		Are you sexually active?	Y N P
Age at last menses? (if menopausal)		Do you use birth control?	Y N P
Typical duration of bleed?	Days	What type?	
Typical length of cycle?	Days	Difficulty conceiving?	Y N P
Are cycles regular?	Y N P	Pain during intercourse?	Y N P
PMS?	Y N P	Number of pregnancies?	
Painful menses?	Y N P	Number of live births?	
Heavy or excessive flow?	Y N P	Number of miscarriages?	
Bleeding between periods?	Y N P	Number of abortions?	
Clotting during menses?	Y N P	Gonorrhea?	Y N P
Unusual vaginal discharge?	Y N P	Herpes?	Y N P
Vaginal itching?	Y N P	Chlamydia?	Y N P
Date of last PAP?		Condyloma? (i.e. genital warts)	Y N P

Abnormal PAP?	Y N P	Syphilis?	Y N P
Cervical dysplasia?	Y N P	Have you had a DEXA bone scan?	Y N P
Endometriosis?	Y N P	Do you do breast self-exams?	Y N P
Ovarian cysts?	Y N P	Breast pain or tenderness?	Y N P
Menopausal Symptoms?	Y N P	Breast lumps?	Y N P
Have you had a mammogram(s)?	Y N P	Nipple Discharge	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Weakness?	Y N P
Broken bones?	Y N P	Sciatica?	Y N P
Muscle spasms or cramps?	Y N P	Backache?	Y N P
Joint swelling?	Y N P	Neck pain/stiffness?	Y N P

Vascular/Neurologic

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet/other?	Y N P
Varicose veins?	Y N P	Extremity swelling?	Y N P
Seizures/convulsions?	Y N P	Numbness or tingling?	Y N P
Muscle weakness?	Y N P	Speech problems?	Y N P
Vertigo?	Y N P	Loss of balance?	Y N P
Paralysis?	Y N P	Involuntary movement?	Y N P
Fatigue?	Y N P	Heat or cold intolerance?	Y N P
Excessive thirst?	Y N P	Hypoglycemia?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P		

Immune

Chronically swollen glands?	Y N P	Chronic infections?	Y N P
Frequent cold/flu?	Y N P	Slow wound healing?	Y N P

Mental/Emotional

Treated for emotional issues?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Phobias?	Y N P	Considered/attempted suicide?	Y N P
		Seasonal depression?	Y N P

Is there anything else that you would like to add or comment on?