Maggie Thibodeau, ND
CARY HOLISTIC HEALTH, LLC
301 Ashville Avenue, Suite 111 / Cary, NC 27518
(919) 858-1004 / CaryHolisticHealth.com

Thank you for scheduling an appointment with Cary Holistic Health.

We are located at 301 Ashville Avenue, Suite 111 – 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 hour for your child's 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 child's 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 child's doctor to have them send records directly to our office. There is a link on our website on the New Patients page.

Please bring with you any vitamins and supplements your child is taking.

The fee for an initial appointment is $120. Follow-up appointments are usually 45 minutes, with a fee of $75. 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 and your child toward better health!

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CHILD INTAKE FORM

PATIENT INFORMATION

Name _____ Date of 1st Visit _____

Date of Birth _____ Age _____ Gender: M F

PARENT/GUARDIAN CONTACT INFORMATION

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

Does this child have siblings?: _____ 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? _____

Has your child received naturopathic treatment in the past? _____

EMERGENCY CONTACT

Name _____ Phone: _____

Relationship _____ Address _____

HEALTHCARE PROVIDERS

Primary Health Care Physician: _____ Phone: _____

When was your child's last physical exam? _____

Is he/she currently under the care of a specialist? _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

List your child's primary health concerns, in order of importance:

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

HEALTH HISTORY

How would you describe your child's general state of health? Excellent Good Fair Poor

Is your child currently being treated for a health concern by other healthcare practitioners? Please explain.

_____

_____

Does your child have any known contagious diseases at this time? Y N If yes, what?

_____

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

	Date		Date

List any X-rays, CT scans, blood work or other studies (hearing, vision, etc.) that your child has had, along with the approximate date.

Study	Date	Study	Date

MEDICATIONS

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

How many times have your child received antibiotics in the past three years? _____

Prescription Medications

Is your child sensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental agents? _____

Any chemicals? _____

Any supplements? _____

Has your child ever had an anaphylactic reaction? _____

Illnesses

What illnesses has your child had?

Scarlet fever ___ Diphtheria ___ Rheumatic fever ___ Mumps ___ Measles ___ German measles (rubella) ___

Chicken pox ___ Impetigo ___ Tuberculosis ___ Mononucleosis ___ Strep throat ___ Ear infections ___

Immunizations

What immunizations has your child had?

DPT (diphtheria, pertussis, tetanus) ___ Hepatitis A ___ Flu shot ___ Haemophilus influenza B ___ Hepatitis B ___

Polio ___ MMR (measles, mumps, rubella) ___ Hepatitis C ___ Smallpox ___ Chicken pox ___ Other: ___

Please indicate if any immunizations caused adverse reactions _____

Adverse Reactions

Please indicate if any of your child's immediate family (parents, siblings, maternal and paternal grandparents) suffers from or has suffered from any of the following conditions

Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Drug abuse/alcoholism	
Depression	
Other Mental Illness	
Asthma / Eczema	
Allergies/Hay fever	
Kidney Disease	
Autoimmune (MS, RA,	
Lupus etc)	
Psoriasis	
Other	
Thyroid issues	

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

Did the mother experience any of the following during pregnancy:

Bleeding ___ High blood pressure ___ Nausea ___ Vomiting ___

Diabetes ___ Thyroid problems ___ Physical/emotional trauma ___

Other _____

Did the mother use any of the following during pregnancy? If so, please list amounts, frequency:

Medications Y N _____

Tobacco Y N _____

Recreational drugs Y N _____

Prescription medications Y N _____

Supplements Y N _____

Birth History

Term length: Full Premature: _____ wks Late: _____ wks

Length of labour: _____ Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-section _____ Induced _____ Forceps _____ Anaesthesia used _____

In the first few weeks, did the child experience any of the following (circle all that apply)?

congenital birth defects colic constipation vomiting

jaundice rashes seizures other _____

Age at first: sitting _____ crawling _____ teething _____ walking _____ talking _____

Diet

Was your child breast fed? Y N If, so for how long? _____

At what age did you introduce solid foods? _____

Are there any foods you exclude from your child's diet? If so, for what reason?

_____

Are there any foods your child craves (chocolate, sweets, salty, rich/fatty, breads, spicy)? _____

How much water does your child drink daily? _____

How often does your child have a bowel movement? _____

Lifestyle

How is your child's energy? _____ Stress level? _____

Does your child exercise regularly? _____ How often? _____ What type? _____

_____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc.)? Please describe.

_____

_____

_____

How many hours of sleep does your child typically get? _____

Any problems with sleep? _____

Describe your child's temperament:

_____

_____

_____

How does you child feel about school/day-care?

_____

_____

_____

What are your child's main interests and hobbies?

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

Is there anything else that you feel is important that has not been covered?

_____

_____

_____