

**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.**

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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 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
- Child 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.

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

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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 has 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.

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How many hours of sleep does your child typically get? \_\_\_\_\_

Any problems with sleep? \_\_\_\_\_

Describe your child's temperament:

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

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What are your child's main interests and hobbies?

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How would you describe the emotional climate of your home?

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

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