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.

If you have a virtual (video) appointment you will receive an invitation before your appointment time.

Plan to spend 1 hour for your initial intake. Please set aside some time prior to your initial visit to complete the forms included in this package and upload them to the member portal.

- *Consent to Treat form*
- *Financial Policy*
- *Adult Intake form*

It is also extremely helpful to **bring any recent blood work or imaging results with you** or upload them to the member portal before your visit. This is best done by sending a message to Dr. Maggie and attaching results to the message. 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 to this form on our website on the Patient Hub page.

Please bring any vitamins and supplements you are taking with you or have them handy for your video/ phone appointment.

If you are unable to keep your scheduled appointment, 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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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 Provider

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?

_____

How long have you suffered with this problem? _____

Any other complaints:

_____

_____

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

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):

_____

_____

Medical History

	Father	Mother	Grand Parents	Brothers	Sisters	Spouse	Child
Age (if living)							
Age when died							
Reason for death							
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/	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

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	#/Week	Food	#/Week	Food	#/Week
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 you exclude from your diet _____
Do you follow a specific diet regime? Vegetarian ____ Vegan ____ Other _____
Any known food allergies/intolerances/sensitivities? _____

Do you smoke tobacco products or have a history of doing so? Y N
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. _____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

Regarding your primary health concern, what have you tried doing to resolve this problem that Did Not work? _____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

_____

How does this problem interfere with the following areas in your life?
Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

Are you here visiting us to:

Resolve my immediate problem
Life style program for optimized living
Both
Other: _____

How have you taken care of your health in the past?

Medications
Routine medical
Exercise
Diet and Nutrition

Holistic
Vitamins
Chiropractic
Other: _____

How did the previous methods work for you?

_____
_____

What are you afraid this might be or will be affecting? Please circle

Job
Kids
Marriage
Sleep

Freedom
Future abilities
Finances
Time

Are there any health conditions you are afraid this might turn into? Please circle

Diminished Future abilities
Stress
Weight gain
Heart disease
Depression

Surgery
Arthritis
Cancer
Diabetes Other:_____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific:

_____

_____

What would be different or better without this problem? Please circle:

Diminished stress
More energy
Self esteem
Confidence

Sleep
Work
Outlook
Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!