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*
- *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 pediatric appointment is $170. 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

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 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. _____

Has your child experienced any traumatic life events that you feel may be associated with any of his/her health concerns?

Health History

How would you describe your child's current state of health? Excellent Good Fair Poor
Is your child currently being treated for a health care 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.

Condition	Date	Condition	Date

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

Study	Date	Study	Date

Has there been an event or illness from which you feel your child has never fully recovered from?

Medications

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies your child is 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 five years? _____

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

_____

Has your child ever had an anaphylactic reaction? Y N

Which immunizations has your child had?
HBV (hepatitis B) _____ Hepatitis A _____ Meningococcal _____ Other: _____
MMR (measles, mumps, rubella) _____ Smallpox _____
Hib (Haemophilus influenza b) _____ Polio _____ Typhus _____
DPT (diphtheria, tetanus, pertussis) _____ VZV (chicken pox) _____ Influenza (flu shot) _____

Please indicate if any immunizations caused 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	
Allergies/hay fever	
Eczema/asthma	
Depression	
Autoimmune disease	
Thyroid disease	
Other	

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 would feel is important?

_____
_____
_____