Dear Patient,

Thank you for the opportunity to be a partner with you in your health care.

We have included several important forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time more effectively. **Please bring these forms to your first office visit.** Your first visit will be a thorough assessment of your health and you will need to allow about one hour.

The physician's recommendations will be reviewed at a second appointment and you should allow about 45 minutes.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as all the bottles of supplements and/or medications you are currently taking.

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

We look forward to seeing you. Our goal is to become a trusted partner in assisting you with your health care needs.

Yours in health,

Carolinas Natural Health Center

p: 704.708.4404 f: 704.708.4417
1126 Sam Newell Rd., Suite A Matthews, NC 28105
www.CarolinasNaturalHealth.com

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing Carolinas Natural Health Center (CNHC) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

CNHC is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. Returned checks are subject to a $25 return fee and no further personal checks will be accepted.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that *cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan* are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a limited visit will be billed at $100.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Thus, for naturopathic visits there is a $100 charge for new patient and a $50 charge for follow-up cancellations. For all other services (massage, acupuncture, etc.), 50% of the service will be charged for late cancellations. Full service fees will be charged if no notice is given.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

Patient or Parent/Guardian Signature _____ Date _____

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Naturopathic Medicine Legal Disclosure

As a valued patient of Carolinas Natural Health Center, it is important to us that you are fully aware of the laws surrounding Naturopathic Medicine in North Carolina.

- The state of North Carolina does not offer a Naturopathic License to Naturopathic Physicians, but our physicians do hold current medical licenses from other states.

  _____ initial

- As a result, our physicians cannot legally prescribe pharmaceutical drugs, perform minor surgeries, administer injections, or diagnose illnesses.
  _____ initial

- Our Naturopathic Physicians are trained as primary care physicians. However, we are unable to fill that role in the state of North Carolina. Because of this, we ask you to maintain your relationship with a primary care physician. If you need a referral, we can provide a list of primary care physicians.
  _____ initial

_____ _____ _____

Signature Printed Name Date

1126 Sam Newell Road, Suite A *** Matthews, NC 28105
P: 704.708.4404 F: 704.708.4417
www.CarolinasNaturalHealth.com

Patient-Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. E-mail is not the same as calling the office; there is no person at the other end of the e-mail – just a computer. You can't tell for certain when your message will be read or even if the doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via e-mail.

- E-mail is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion.
- E-mail should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential!** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become part of the medical record when we use it; a copy may be printed and placed in your chart.
- **E-mail is not a substitute for seeing your physician**. If you think that you need to be seen, please call and schedule an appointment!
- E-mails may be forwarded to our staff for handling, if appropriate.

Finally either party can revoke permission to use the e-mail system at any time.

☐ I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

CONFIDENTIAL PATIENT REGISTRATION FORM

Date:_____

New Patient Information

Name:_____ _____ DOB: ___/___/___ Age:_____
(Last) ***(First)*** ***(Sex)***

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email Address: _____Would you like to receive our email newsletter? Y N

Additional Patient Information

Primary Care Physician: _____Physician's Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Marital Status(circle): Single Married Separated Divorced With Partner Widow(er)

Number of Children:_____

Name of Spouse/Partner: _____

Emergency Contact: _____ Relationship to you: _____

Emergency Contact #: (___)_____

Referral Information

How did you hear of us? _____

Were you referred by a physician?: ☐ Yes ☐ No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number: _____

Entered by:_____

CAROLINAS NATURAL HEALTH CENTER

NATUROPATHIC PATIENT INTAKE FORM

Patient Name: _____ **DOB:**_____

List in order of importance what your health concerns are:

1) _____
2) _____
3) _____
4) _____
5) _____

Last time you had blood work done and with what physician: _____

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	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
Heart Disease:	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
Mental Illness:	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
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	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

List all surgeries & hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please note when & why you have had each of the following:

X-Rays: _____ MRI/Cat Scans: _____

Ultrasounds: _____ Accidents: _____

TB Test: _____ Hepatitis C: _____

HIV: _____ Last Dental Visit: _____

Last Eye Exam: _____

Patient Name: _____ **DOB:** _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N
Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N
German Measles: D I N **Any vaccination reactions:** _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____
Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____
Soda Pop: Y N P **Ounces per day if Yes/Past**: _____
Alcohol: Y N P **How often & how much if Yes/Past**: _____
Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P
Recreational Drugs: Y N P **Any Drug Addictions**: Y N P
Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

_____
_____
_____

List all known drug allergies and reaction you get when you take the medication:

_____
_____
_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____
Maximum weight and when: _____ **Minimum weight as adult & when**: _____
Ideal Weight: _____

REGARDING THE NEXT SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

Patient Name: _____ **DOB:** _____

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

Patient Name: _____ **DOB:** _____

		RESPIRATORY		
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
		CARDIOVASCULAR		
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
		URINARY TRACT		
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
		GASTROINTESTINAL		
Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P
		MALE HEALTH		
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi

Patient Name: _____ **DOB:** _____

FEMALE HEALTH			
Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Bone Scan:	Y N P	**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P
NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P
MENTAL/EMOTIONAL			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Patient Name: _____ **DOB:** _____

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long? _____ **Hobbies**: _____

Sleep

How long per night? _____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P **Hours worked per week**: _____ **Highest Level of Education**: _____

Active spiritual practice: Y N P **Quality of significant relationship**: _____

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom**: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, environment): _____