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 during your wellness consultation. Your detailed and thoughtful responses will help us to utilize our time more effectively. **Please bring in these forms with you.**

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 all the bottles of supplements and/or medications you are currently taking as well as copies of any recent lab work.

Our goal is to become a trusted partner in assisting you with your health care needs. We are excited about your commitment to optimal health and look forward to seeing you.

Yours in health,

Carolinas Natural Health Center

1212 Mann Drive, Suite 100 ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404 ☼ Fax: 704-708-4417

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:_______________________

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.

We are sensitive to those with special financial needs and will consider a sliding scale for qualified individuals.

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 $90.

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

1212 Mann Drive, Suite 100 ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404

WELLNESS INTAKE FORM

Patient Name: ____________________ **DOB:** __________

List in order of importance your health goals: **Age:** __________

1) ____________________
2) ____________________
3) ____________________
4) ____________________

When was your most recent lab work completed: ____________________

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
High Cholesterol	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
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 Test: ____________________ 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**: ________
Tea: Y N P **Cups per day __________** **Soda Pop**: Y N P **Ounces per day if Yes/Past**: _______
Alcohol: Y N P **How often & how much if Yes/Past**: __________
Recreational Drugs: Y N P **Any Addictions**: Y N P **Explain:** ___________________________________

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

____

____

____

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

____

____

____

Allergies

List all known Allergies (food, environment, natural supplements): ________________________________

____

____

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 0 1 2 3 4 5 6 7 8 9 10 - 0 being NONE, 10 being High Energy
Fatigue: Y N P 0 1 2 3 4 5 6 7 8 9 10 - 0 being Slight fatigue, 10 being Completely fatigued
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:** _____________

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

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

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 **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 **If so, at what age and by whom**: ________

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

Typical Day's Diet

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Fluids: ____

Patient Name: ______________________________ **DOB:** ________

SKIN				
Rash:	Y N P	Notes:	**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema: (Circle)	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles: (Circle)**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P	Notes:	**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	Notes:	**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: (Circle)	Y N P	Notes:	**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	Notes:	**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

Patient Name: ______________________________ **DOB:** __________

RESPIRATORY				
Cough:	Y N P	Notes:	**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	Notes:	**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	Notes:	**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	Notes:	**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

MEN ONLY				
Testicular pain/swelling:	Y N P	Notes:	**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:** ____________

WOMEN ONLY				
Age Period Began:		Notes:	**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	Notes:	**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	Notes:	**Sciatica:**	Y N P
Tingling/numbness:	Y N P		**Carpal tunnel:**	Y N P
Seizures:	Y N P		**Fainting:**	Y N P

MENTAL/EMOTIONAL				
Depression:	Y N P	Notes:	**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