



Dear Parent/Guardian:

Thank you for the opportunity to be a partner in your family's 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 in these forms to your first office visit.** The first visit will be a thorough assessment of your child's health and you should allow up to one and a half hours for the visit.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior 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 that your child is currently taking.

We look forward to meeting you and your family. Our goal is to become a trusted partner in assisting you with your family's health care needs.

Yours in Health,

Carolinas Natural Health Center



PEDIATRIC PATIENT REGISTRATION FORM

Date: _____

New Patient Information

Name: _____ DOB: ____ / ____ / ____ Age: _____
(Last) (First) (Sex)

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Parent/Guardian Email : _____ Would you like to receive our email newsletter? Y N

Additional Patient Information

Pediatrician: _____ Phone: (____) _____

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

Mother's Name: _____ Occupation: _____ Tel: _____

Father's Name: _____ Occupation: _____ Tel: _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Whom may we contact in case of an emergency: _____ Relationship to patient: _____

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



NATUROPATHIC PEDIATRIC INTAKE FORM

Today's Date: _____

Patient Name: _____ DOB: _____

Sex (m/f): ___ Grade of School: ___ Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

When was the most recent lab work and with what physician?: _____

List All Surgeries & Hospitalizations, including date occurred:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List All medicines (from drugstore or prescription) child is on now:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List all supplements child is taking:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Any known Allergies to food, drugs, environment, animals: _____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly**; **NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently**. **Please circle the correct one for your child.**

Ear Infections: Y N P

If has had, how many total: _____

Colds: Y N P

If has had, how many total: _____

Strep Throat: Y N P

If has had, how many total: _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken and how often:

- 1) _____ 3) _____
2) _____ 4) _____

Hearing Tests Normal: Yes No Not Tested Speech Impediments: Yes No Past

Vision Tests Normal: Yes No Not Tested Learning Impediments: Yes No Past

Patient Name: _____

DOB: _____

Vaccination History:

YES, has had; NO, has not; SOME, did not finish all shots:

MMR: Yes No Some

DPT: Yes No Some

Hep B: Yes No Some

Hib: Yes No Some

Chicken Pox: Yes No Some

Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History:

Allergies: Y N P

Obesity: Y N P

Cancer: Y N P

Tuberculosis: Y N P

Mental Illness: Y N P

Cardiovascular Disease: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History:

Age at conception: _____

Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Y N

Diabetes: Y N

Coffee: Y N

Nausea/Vomiting: Y N

Recreational Drugs: Y N

Emotional Stress: Y N

Preeclampsia: Y N Length of Labor: _____

Vaginal Birth: Y N

Traumatic Birth: Y N

If the birth was difficult, please explain: _____

Health of baby at birth: _____

Health History of Child:

Child Breastfed: Y N

For how Long: _____ When put on formula: _____

What Formula was used: _____ When was child put on solid food: _____

When did child walk: _____ Talk: _____ Develop Teeth: _____

Jaundice as baby:	Y N	Colic:	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Patient Name: _____ DOB: _____

Any Particular household stressors child has witnessed or gone through:

- 1) _____ 2) _____
3) _____ 4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution was s/he exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

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



Pediatric Homeopathic General Form

Name: _____

Date: _____

The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy 1 2 3 4 5 6 7 8 9 10 Clear

Wet 1 2 3 4 5 6 7 8 9 10 Dry

Damp cold 1 2 3 4 5 6 7 8 9 10 Snow (Dry cold)

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble?

Winter 1 2 3 4 5 6 7 8 9 10 Spring
Fall 1 2 3 4 5 6 7 8 9 10 Summer

Are you affected being in the:

Mountains 1 2 3 4 5 6 7 8 9 10 Seashore

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

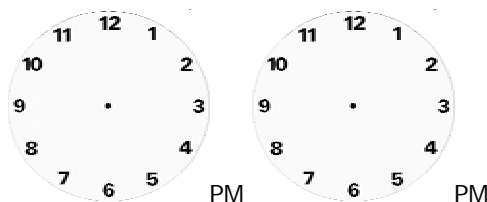
Are you generally chilly or warm?

Chilly 1 2 3 4 5 6 7 8 9 10 Warm

Which are you generally most sensitive to, warm or cold?

Cold 1 2 3 4 5 6 7 8 9 10 Warm

What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?



Symptoms during sleep. Circle which you have.

- Tooth Grinding
- Restlessness
- Talking
- Perspiration
- Frequent Urination
- Excess Heat or Cold
- Laughing
- Snoring
- Nightmares
- Recurring Dreams
- Sleepwalking

Circle what you prefer. Do you sleep:

- Without Covers
- Partly Covered
- Fully Covered (Not including Head)
- Fully Covered (Including Head)
- With Arms or Legs Out of the Covers
- Without Clothing
- With a Fan or Air Blowing on You
- With the Window open

What position do you sleep in most often?

- Right Side
- Left Side
- On Back
- On Abdomen



Pediatric Homeopathic General Form

How much do you perspire?

Never All the Time
 1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

Coffee

1 2 3 4 5 6 7 8 9 10

Pastries

Do you have difficulty waking?

Never All the Time
 1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

Eggs

1 2 3 4 5 6 7 8 9 10

Fat (meat)

1 2 3 4 5 6 7 8 9 10

Fish

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

1 2 3 4 5 6 7 8 9 10

Fruit

1 2 3 4 5 6 7 8 9 10

Fruit (sour)

1 2 3 4 5 6 7 8 9 10

Grain foods

1 2 3 4 5 6 7 8 9 10

Ham

1 2 3 4 5 6 7 8 9 10

Ice

1 2 3 4 5 6 7 8 9 10

Ice cream

1 2 3 4 5 6 7 8 9 10

Indigestible things

1 2 3 4 5 6 7 8 9 10

Lemonade

1 2 3 4 5 6 7 8 9 10

Meat

1 2 3 4 5 6 7 8 9 10

Milk

1 2 3 4 5 6 7 8 9 10

Nut butters

1 2 3 4 5 6 7 8 9 10

Oysters

1 2 3 4 5 6 7 8 9 10

Pickles

1 2 3 4 5 6 7 8 9 10

Vegetables

1 2 3 4 5 6 7 8 9 10

Vinegar

Tastes:

1 2 3 4 5 6 7 8 9 10 Sweet

1 2 3 4 5 6 7 8 9 10 Sour

1 2 3 4 5 6 7 8 9 10 Salty

1 2 3 4 5 6 7 8 9 10 Bitter

1 2 3 4 5 6 7 8 9 10 Spicy (hot)

1 2 3 4 5 6 7 8 9 10 Smoked

1 2 3 4 5 6 7 8 9 10 Juicy

1 2 3 4 5 6 7 8 9 10 Refreshing

1 2 3 4 5 6 7 8 9 10 Pungent

Foods:

1 2 3 4 5 6 7 8 9 10 Alcohol

1 2 3 4 5 6 7 8 9 10 Apples

1 2 3 4 5 6 7 8 9 10 Bacon

1 2 3 4 5 6 7 8 9 10 Bread alone

1 2 3 4 5 6 7 8 9 10 Bread w/ butter

1 2 3 4 5 6 7 8 9 10 Butter alone

1 2 3 4 5 6 7 8 9 10 Cheese

1 2 3 4 5 6 7 8 9 10 Chocolate

Temperature of food. Which do you prefer?

Warm Food Cold Food
 1 2 3 4 5 6 7 8 9 10

Warm Drinks Cold Drinks
 1 2 3 4 5 6 7 8 9 10



Pediatric Homeopathic General Form

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

How thirsty are you generally?

Not at all Very
1 2 3 4 5 6 7 8 9 10

Mental and Emotional State:

How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

Anxiety (worry and fear)
1 2 3 4 5 6 7 8 9 10

Do you worry about any of the following?
10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Function

1 2 3 4 5 6 7 8 9 10 Morals

1 2 3 4 5 6 7 8 9 10 Others well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

1 2 3 4 5 6 7 8 9 10 Irresolution (not being able to decide or stick to a decision)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness, changeable & erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Frightened Easily Never Afraid
1 2 3 4 5 6 7 8 9 10

Answer as honestly as you can about your personality traits.

Stingy Overly generous
1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow
1 2 3 4 5 6 7 8 9 10

Messy Fastidious
1 2 3 4 5 6 7 8 9 10

Calm Restlessness
1 2 3 4 5 6 7 8 9 10

Indolence (Lazy) Always busy
1 2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful Outgoing
1 2 3 4 5 6 7 8 9 10

Anger Mildness
1 2 3 4 5 6 7 8 9 10

Lack of moral sense Guilty
1 2 3 4 5 6 7 8 9 10

Obstinate (stubborn) Yielding
1 2 3 4 5 6 7 8 9 10

Heedless/Reckless Cowardice
1 2 3 4 5 6 7 8 9 10

Social/Antisocial. In regard to being with other people or in company?

Aversion Desire for
1 2 3 4 5 6 7 8 9 10



Pediatric Homeopathic General Form

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

- Resolved Grief
- Dwells on Past
- Inconsolable
- Remorse
- Guilt

Feeling towards people close to you:

- Loving
- Affectionate
- Indifferent
- Resentment
- Hatred
- Other_____

Feeling toward disease/condition:

- Optimistic
- Doubtful of recovery
- Discouraged
- Fearful
- Despair of recovery
- Other_____

Feeling toward life

- Love life
- Indifferent
- Bored
- Weary of life
- Loathing of life
- Desires death
- Suicidal thoughts
- Suicidal disposition
- Other_____

How much do you have the following symptoms?

10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

Alternating Moods Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

- Morose**
- Sad
- Apathy/Indifferent
- Excitement
- Exhilaration
- Other_____

How do you experience sympathy or consolation?

Like Dislike
1 2 3 4 5 6 7 8 9 10

Better from Worse from
1 2 3 4 5 6 7 8 9 10

How talkative are you in general?

Aversion to talking Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance (predict future events)?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10



Pediatric Homeopathic General Form

How afraid are you of the following?

(1, never. 10, very afraid)

It is common for children to have fears, but if the fear is stronger than normal please indicate.

- | | |
|----------------------|------------------------------|
| 1 2 3 4 5 6 7 8 9 10 | Animals |
| 1 2 3 4 5 6 7 8 9 10 | Being alone |
| 1 2 3 4 5 6 7 8 9 10 | Death |
| 1 2 3 4 5 6 7 8 9 10 | Relative's
Death |
| 1 2 3 4 5 6 7 8 9 10 | Impending
Disease |
| 1 2 3 4 5 6 7 8 9 10 | Downward
Motion |
| 1 2 3 4 5 6 7 8 9 10 | Evil |
| 1 2 3 4 5 6 7 8 9 10 | Falling |
| 1 2 3 4 5 6 7 8 9 10 | Ghosts |
| 1 2 3 4 5 6 7 8 9 10 | Heights |
| 1 2 3 4 5 6 7 8 9 10 | Insanity |
| 1 2 3 4 5 6 7 8 9 10 | Misfortune
(bad luck) |
| 1 2 3 4 5 6 7 8 9 10 | Of a Crowd |
| 1 2 3 4 5 6 7 8 9 10 | People |
| 1 2 3 4 5 6 7 8 9 10 | Robbers |
| 1 2 3 4 5 6 7 8 9 10 | Snakes |
| 1 2 3 4 5 6 7 8 9 10 | Spiders |
| 1 2 3 4 5 6 7 8 9 10 | Strangers |
| 1 2 3 4 5 6 7 8 9 10 | Something bad will
happen |
| 1 2 3 4 5 6 7 8 9 10 | Darkness |
| 1 2 3 4 5 6 7 8 9 10 | Thunderstorms |
| 1 2 3 4 5 6 7 8 9 10 | Water |
| 1 2 3 4 5 6 7 8 9 10 | Wind |

Are you forgetful of any of the following?

(1 not at all, 10 a lot)

- | | |
|----------------------|------------------------------|
| 1 2 3 4 5 6 7 8 9 10 | Dates |
| 1 2 3 4 5 6 7 8 9 10 | Names |
| 1 2 3 4 5 6 7 8 9 10 | Numbers |
| 1 2 3 4 5 6 7 8 9 10 | Of what someone just
Said |
| 1 2 3 4 5 6 7 8 9 10 | Of what you just said |
| 1 2 3 4 5 6 7 8 9 10 | Of words |

How often do you make mistakes with the following?

- | | |
|----------------------|----------|
| 1 2 3 4 5 6 7 8 9 10 | Numbers |
| 1 2 3 4 5 6 7 8 9 10 | Reading |
| 1 2 3 4 5 6 7 8 9 10 | Speaking |
| 1 2 3 4 5 6 7 8 9 10 | Writing |

How sensitive are you to any of the following?

- | | |
|----------------------|-------------------------|
| 1 2 3 4 5 6 7 8 9 10 | Beauty |
| 1 2 3 4 5 6 7 8 9 10 | Criticism |
| 1 2 3 4 5 6 7 8 9 10 | Cruel Stories |
| 1 2 3 4 5 6 7 8 9 10 | Frightening things |
| 1 2 3 4 5 6 7 8 9 10 | Being made fun of |
| 1 2 3 4 5 6 7 8 9 10 | Music |
| 1 2 3 4 5 6 7 8 9 10 | Reprimand |
| 1 2 3 4 5 6 7 8 9 10 | Rudeness |
| 1 2 3 4 5 6 7 8 9 10 | The suffering of others |

