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 these forms in at your first office visit.** The first visit will be a thorough assessment of your child's health and you should allow up to 1 ½ 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.

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 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

p: 704.708.4404 f: 704.708.4417
1126 Sam Newell Road, 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

______________________________   ______________________________

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

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: ____________

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:_________________

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

1126 Sam Newell Rd., Suite A ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404 ☼ Fax: 704-708-4417

Rev. 07/07

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 Spring
Fall 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?

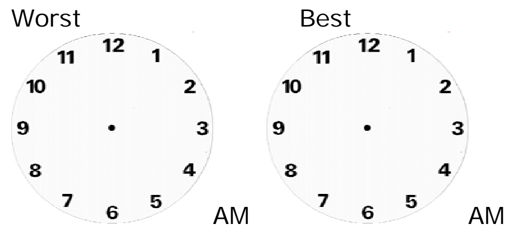
Chilly 1 2 3 4 5 6 7 8 9 10 Warm

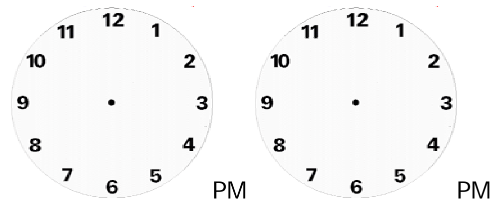
Which are you generally most sensitive to, warm or cold?

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?

Worst 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 On Back
Left Side 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

Do you have difficulty waking?

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

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.

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

1 2 3 4 5 6 7 8 9 10 Coffee

1 2 3 4 5 6 7 8 9 10 Pastries

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

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

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

Pediatric Homeopathic General Form

How do you usually handle conflict?

Quarrelsome — Yielding
1 2 3 4 5 6 7 8 9 10

How are you in regard to authority?

Bossy/Dictatorial — Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie — Always honest
1 2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary-opposite to what is logically expected

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence