

Catawba Natural Healing

Female Intake Form

Known allergies (food, medications, or other): _____

Any metal implants in the body? If yes, where and since when: _____

Contact Information

Today's Date: ___ / ___ / ___

Name: _____

DOB: ___ / ___ / ___ Age: ___

Street: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

If mailing address is different: _____

Martial Status: M S D W # of Children: _____ Alternative Phone Number: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

How did you find out about us? _____

Have you had acupuncture before? Y N Allow email/mail/text/phone contact by this clinic? Y N

Medical Team

Who is currently part of your medical team (PCP, specialists, massage therapist, chiropractor, etc.):

Who do you allow to have access to your medical chart so that we can discuss about your health and

treatments with them? Full name: _____ Relationship: _____

Major Health Complaint(s)

Please list in order of significance to you (include when the problem began and precipitating factors) and

check which you would like us to focus on today.

1. _____

2. _____

3. _____

Have you been given a diagnosis for this problem? If so, please describe _____

What kind of treatments have you tried? _____

What makes this problem worse? _____ Better? _____

Is there anybody in your family with the same problem? _____



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Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P C <input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Abuse	P C <input type="checkbox"/> <input type="checkbox"/> Digestive Disorder	P C <input type="checkbox"/> <input type="checkbox"/> Hypertension	P C <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> <input type="checkbox"/> Auto Immune	<input type="checkbox"/> <input type="checkbox"/> Heavy Bleeding/Hemorrhage	<input type="checkbox"/> <input type="checkbox"/> Mental Illness	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Migraines	<input type="checkbox"/> <input type="checkbox"/> Vein Condition
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Other: _____	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> HIV/Hepatitis		

Significant trauma (car accident, sports injuries etc.): _____

Hospitalizations/Surgeries (procedures and dates): _____

Allergy shots? Currently In the past Never

Cortisone shots? Currently In the past Never how many total have you had: _____

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

Family Medical History (please specify family member)

<input type="checkbox"/> Alcoholism/Drug Abuse _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Asthma/Allergies _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Miscarriage _____
<input type="checkbox"/> Depression/Mental Illness _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Other _____	

Current Health & Lifestyle

Do you smoke? Y N If yes, how many per day? _____ For how long? _____

Do you drink alcohol? Y N If yes, how much per day? _____ For how long? _____

Do you use recreational drugs? Y N If yes, what do you use? _____

How much per day? _____ For how long? _____

Do you exercise? Y N If yes, how many times per week? _____ Please Describe. _____

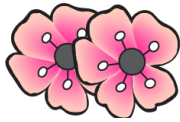
Do you travel frequently? Y N Have you traveled overseas to 'developing' countries? Y N

Do you sit in traffic/commute as a daily routine? Y N

Height: _____ Weight: Now _____ One year ago _____ Maximum _____ @ Year _____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

How would you describe the quality of your sleep? _____



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Overall, do you feel that your lifestyle contributes to or takes away from your health? _____

Diet

Please describe your average daily diet **and include the time of when you typically eat:**

Breakfast: _____

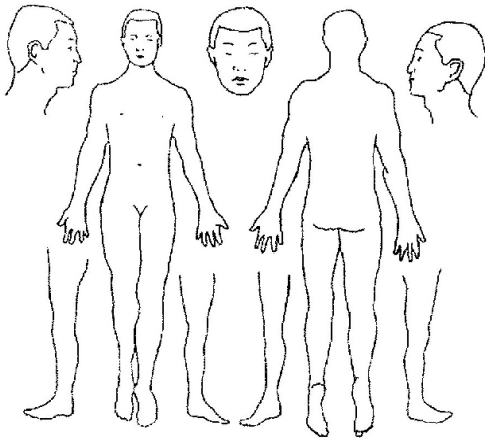
Lunch: _____

Dinner: _____

Snacks: _____

Foods you tend to crave: _____

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:	
XXX	Sharp / Stabbing
PPP	Pins and Needles
DDD	Dull / Aching
NNN	Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Profile

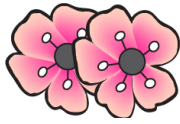
Please check any of the following symptoms that **currently** pertain to you.

General

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Perspire easily | <input type="checkbox"/> Strong thirst |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweating | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back |
| <input type="checkbox"/> Broken/loose teeth | <input type="checkbox"/> Ringing in ears/tinnitus | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips/buttocks |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Early graying of hair | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Cold knees |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weak nails |

Emotions

- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fits of laughter | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent worrying |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anger | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Mania | |



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Skin

- | | | | |
|-----------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry or Flaky Skin | <input type="checkbox"/> Hives | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ulcerations/Boils |

Neuro-Muscular

- | | | | |
|------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Muscle spasms | |

Cardiovascular

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Tongue ulcers | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hallucinations |

Respiratory

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Chest congestion | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Frequent colds/flu | | | |

Gastrointestinal

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Strong cravings |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Gas | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Less than 1 BM per day | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Difficulty moving bowels | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Diarrhea |

Lymphatic System/Accumulated Dampness

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Mental fogginess | <input type="checkbox"/> Edema in the legs | <input type="checkbox"/> Heavy limbs/head |
| <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Edema in the abdomen | <input type="checkbox"/> Joint stiffness |

Liver/Gall Bladder Function

- | | | | | |
|------------------------------------|------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Pain in ribcage | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Chronic neck or shoulder tension |
|------------------------------------|------------------------------------|--|--------------------------------------|---|

Eyes

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Red and irritated eyes | <input type="checkbox"/> Floaters/Seeing spots | <input type="checkbox"/> Glaucoma |
| | | | <input type="checkbox"/> Blurry vision |

Urinary

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Large amount | <input type="checkbox"/> Difficulty initiating urination | <input type="checkbox"/> Strong odor |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Pain or burning |
| <input type="checkbox"/> Reddish color | | | |

Female

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Frequent vaginal infections |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Abnormal vaginal discharge |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Pain during intercourse | <input type="checkbox"/> Night sweats |



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Do you experience any of the following associated with your period each month?

- Water retention Migraine/headache Lower back pain Change in bowel movement
 Mood swings Irritability Abdominal cramps Breast tenderness/swelling
Food cravings Acne Heavy bleeding Scanty/light bleeding
 Clots Other: _____

_____ number of pregnancies _____ number of live births _____ miscarriages _____ abortions
_____ premature births _____ difficult delivery _____ cesareans

At what age did you get your first period: _____ First day of last menstrual period: _____

Are your menstrual cycles spaced regularly? Y N Cycle length: _____ Period length : _____

Are you currently using birth control? Y N If yes, what type and for how long? _____

Have you experienced menopause? Y N When? _____

If you are experiencing menopausal symptoms, please describe: _____

Is there any possibility you are pregnant now? Y N

Add up the total number of current symptoms you have and write it here: _____

Additional info you would like Dr Amy Lor to know that may have not been listed above:



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Medications and Supplements: Medications you are currently taking. Must include full name of product including the manufacturer (unless it is a prescription, then just full name), your dosing, and your reason for taking the product. **Bring all products to your visit!**

Date started	Prescription/OTC meds/supplement/teas/powders	Reason for use

By signing, client admits that all information provided is true and accurate.

Client Signature Date

Reviewed by Date



Catawba Natural Healing

CATAWBA NATURAL HEALING LLC CONSENT TO TREATMENT/CONSULTATIONS AND FINANCIAL AGREEMENT

Consent

I voluntarily consent to such diagnostic procedures, care and recommendations deemed necessary by the physician, his or her assistant or designated consultants. I understand that Traditional Chinese Medicine and Naturopathic Medicine is not an exact science and I further acknowledge that no guarantees have been made to me as to the result of examination, treatment or consultation in this clinic. I understand that Dr. Amy is not licensed and registered as a Naturopathic physician in the state of North Carolina since there is no licensure and registration for Naturopathic doctors in North Carolina. I understand that as a Naturopathic doctor in the state of North Carolina, Dr Amy can only provide consultations and recommendations. She does not make western diagnosis and does not substitute as a primary care physician.

Financial agreement

I understand and acknowledge that I am responsible for all charges rendered at the time of service and that payment is to be collected immediately after my appointment in the form of cash, a personal check or by using a credit, FSA or HSA card.

Catawba Natural Healing LLC is a cash-based practice and **do not accept** health insurances and we do not file out of network health insurance paperwork.

I understand that a credit card is required to be kept on file electronically and an authorization form must be signed to be able to book for appointments. This credit card can be charged upon the request of the client and/or when there is a remaining balance unpaid after several attempts to collect.

I can find a detailed financial policy by accessing Catawba Natural Healing’s website or by requesting one in office or by phone call.

Personal valuables

I understand that Catawba Natural Healing is not responsible for personal valuables brought into the clinic or left in my vehicle.

Recording or filming

Recording or filming (to include photographs, video, electronic or audio media): I understand that from time to time Catawba Natural healing may record or film me while care or consultations are being provided (for example: photo documentation of injuries, tongue, etc). I understand these recording films/ photos will only be viewed internally for identification purposes, for the treatment, diagnosis or evaluation by Traditional Chinese Medicine; or for naturopathic medicine consultations.

Release of Information and Notice Privacy Practices

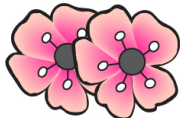
I authorize Catawba Natural Healing to release information necessary for external and internal quality improvement activities including information required by regulatory and accrediting bodies. As described in the Notice of Privacy Practices, Catawba Natural Healing may allow health care providers to have access to my medical information for treatment, payment and health care operations.

I have read the consent to treatment and financial agreement. I understand and agree to its terms. My signature below acknowledges that I have been given the opportunity to receive a full disclosure of the privacy practices as outlines by the health insurance portability and accountability act of 1996. This can also be accessed by going to www.catawbanaturalhealing.com

Client printed name: _____

Client’s or responsible party signature

Date



Catawba Natural Healing

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Payment is to be collected immediately after treatment. Any payments made by cash or personal check will receive a \$5 time of service discount.

<u>Service</u>	<u>Rate</u>
Case Review (Initial Intake)	\$255
Naturopathic follow-up consultations 10-60 min *Include Botanical Medicine & Supplement consultations	\$125-\$400 *rate dependent on complexity
Naturopathic consultation & Acupuncture *Include Botanical Medicine & Supplement consultations *Includes far infrared heat lamp	\$225
Acupuncture follow-up treatments *Include Botanical Medicine & Supplement consultations *Includes far infrared heat lamp	\$125
Acupuncture with E-Stim *Include Botanical Medicine & Supplement consultations *Includes far infrared heat lamp	\$155
30 minutes cupping	\$55
Up to 10 minutes cupping or gua sha (spooning) *Includes far infrared heat lamp	\$20
Tui Na (massage) full hour	\$125
Tui Na up to 30 min *includes far infrared heat lamp	\$63
Lab recommendations	\$35
Lab results review	\$30-\$100
Medical chart review from other providers *either requested from your medical provider(s) or that you brought in	\$65
Add on 15 minutes; 30 minutes	\$25; \$50

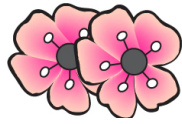
Other fees:

No Show: \$60

Less than 24-hour cancellation: \$60

Returned check fee: \$25

All sales are final: Herbal or supplement purchases are non-refundable. Herbal or supplemental sales are only for patients of Catawba Natural Healing LLC.



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No shows/less than 24 hour cancellations: We understand that things come up and you may need to cancel last minute or can't show up. As a courtesy, we will waive either your first no show or first less than 24 hour cancellation, whichever is first.

The exception is that if you have an appointment scheduled on Monday, we ask that you call us by Friday to avoid any cancellation fees. In the event that you did have to cancel with less than 24 hour notice or there's a no show, we will send out a letter outlining the clinic policy regarding missed appointments.

You are allowed a TOTAL of 3 no shows/less than 24 hour cancellation before your care is discontinued. Your practitioner will mail you a certified letter explaining the discontinuance of your care and provide appropriate referral(s) for you within 10 business days. No show fees/cancellation fees will still apply as indicated in the financial agreement. Please inquire more about it by either calling our office at 828-999-4800. Invoices unpaid after 30 days are subject to 5% finance charge per week plus a one-time \$25 late fee. In the event any third parties are involved to collect any outstanding monies owed by said business, the customer/patient agrees to pay any reasonable collection fees, including attorney fees whether litigation has commenced, and all costs of litigation. **All overdue balances must be paid prior to next appointment.**

New client: If you have booked for your first personalized or a free consultation appointment, it is important that you show up. Failure to do so will result in immediate termination from the clinic and you will not be able to book for another appointment. We have a commitment to help our clients and we hope that you value your health as well as the time that we've set aside for you. Thank you for understanding.