Catawba Natural Healing

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

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)

☐ Alcoholism/Drug Abuse_____ ☐ Heart Disease_____
☐ Asthma/Allergies_____ ☐ Hypertension_____
☐ Cancer_____ ☐ Miscarriage_____
☐ Depression/Mental Illness_____ ☐ Osteoporosis_____
☐ Diabetes_____ ☐ Stroke_____
☐ 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?_____

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How would you describe the quality of your sleep? _____

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:_____

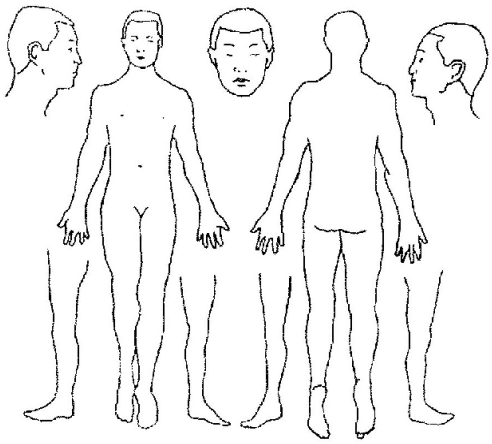
Lunch:_____

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

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

Emotions

☐ Mood swings	☐ Anxiety	☐ Fits of laughter	☐ Fear
☐ Sadness	☐ Panic attacks	☐ Depression	☐ Frequent worrying
☐ Nervousness	☐ Irritability	☐ Anger	☐ Easily stressed
☐ Bipolar	☐ Obsessive/Compulsive	☐ Mania	

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Skin

- ☐ Acne
- ☐ Dandruff
- ☐ Dry or Flaky Skin
- ☐ Eczema
- ☐ Hives
- ☐ Psoriasis
- ☐ Rashes
- ☐ Ulcerations/Boils

Neuro-Muscular

- ☐ Seizures
- ☐ Paralysis
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Tingling in extremities
- ☐ Muscle spasms
- ☐ Numbness

Cardiovascular

- ☐ Heart palpitations
- ☐ Restless dreams
- ☐ Chest Pain/Angina
- ☐ Mental restlessness
- ☐ Tongue ulcers
- ☐ Insomnia
- ☐ Speech impediment
- ☐ Hallucinations

Respiratory

- ☐ Persistent cough
- ☐ Nosebleeds
- ☐ Sinus congestion
- ☐ Frequent colds/flu
- ☐ Nasal dryness
- ☐ Chronic allergies
- ☐ Sore throats
- ☐ Chest congestion
- ☐ Sneezing
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Difficulty Breathing
- ☐ Shortness of breath

Gastrointestinal

- ☐ Indigestion
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Low or weak appetite
- ☐ Gurgling in intestines
- ☐ Bruise easily
- ☐ Fatigue following a meal
- ☐ Easily fatigued
- ☐ Gas
- ☐ Hypoglycemia
- ☐ Strong cravings
- ☐ Hemorrhoids

- ☐ Stomach ache
- ☐ Acid reflux
- ☐ Bad breath
- ☐ Ravenous appetite
- ☐ Bleeding gums
- ☐ Heartburn
- ☐ Stomach ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Nausea
- ☐ Vomiting
- ☐ Mouth ulcers

- ☐ Loose stools
- ☐ Mucous in stools
- ☐ Blood in stools
- ☐ Difficulty moving bowels
- ☐ Less than 1 BM per day
- ☐ Small, hard, dry stools
- ☐ Constipation
- ☐ Diarrhea

Lymphatic System/Accumulated Dampness

- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Mental fogginess
- ☐ Mental sluggishness
- ☐ Edema in the legs
- ☐ Edema in the abdomen
- ☐ Heavy limbs/head
- ☐ Joint stiffness

Liver/Gall Bladder Function

- ☐ Headaches
- ☐ Migraines
- ☐ Pain in ribcage
- ☐ Gall stones
- ☐ Chronic neck or shoulder tension

Eyes

- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Red and irritated eyes
- ☐ Poor night vision
- ☐ Floaters/Seeing spots
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blurry vision

Urinary

- ☐ Cloudy
- ☐ Dark yellow
- ☐ Clear color
- ☐ Reddish color
- ☐ Small amount
- ☐ Large amount
- ☐ Dribbling
- ☐ Night-time urination
- ☐ Difficulty initiating urination
- ☐ Very frequent
- ☐ Incontinence
- ☐ Strong odor
- ☐ Pain or burning

Male

- ☐ Prostate Problems
- ☐ Low sex drive
- ☐ Nocturnal emission
- ☐ Low sperm count
- ☐ Feeling of coldness or numbness of genitalia
- ☐ Testicular pain/swelling
- ☐ Premature ejaculation
- ☐ Infertility
- ☐ Poor sperm motility
- ☐ Ejaculation problems
- ☐ Erectile dysfunction/impotence
- ☐ Difficulty maintaining an erection
- ☐ Irregular sperm morphology
- ☐ Discharge

Do you have any bothersome symptoms? Y ☐ N ☐ Describe:_____

Do you get up at night to urinate? Y ☐ N ☐ How often?_____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____

Have you sought medical intervention for these problems? If so, when?_____

_____

What treatment have you tried for these problems and how successful have they been?

_____

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.**

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 AGREEMEMENT

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. Lor 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 Lor 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 /uptodate 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**