

Catawba Natural Healing

Pediatric Male Intake Form (0-17 years old)

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

Contact Information

Today's Date: ___ / ___ / ___

Name: _____ Sex: F M DOB: ___ / ___ / ___ Age: ___

Street: _____ Email Address: _____

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

Marital 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

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: _____

Medical Team

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

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? _____

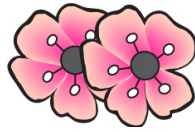
Is there anybody in your family with the same problem? _____

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 Alcohol/Drug Abuse **P C** Digestive Disorder **P C** Hypertension **P C** Nervous Disorder



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- | | | | |
|---|---|--|--|
| <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.): _____

Immunizations up to date: Y N

Hospitalizations/Surgeries (procedures and dates): _____

Dental Procedures (include any silver fillings/mercury amalgams): _____

Do you have a history of frequent antibiotic use? Please Describe. _____

Allergy shots? Currently In the past Never

Cortisone shots? Currently In the past Never

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

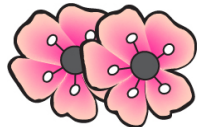
Do you sit in traffic/commute as a daily routine? Y N

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

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

List 3 things you do currently that support your overall health.

List your 3 favorite vices (eg smoking, social drinking, sweet tooth...)



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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:

Breakfast: _____

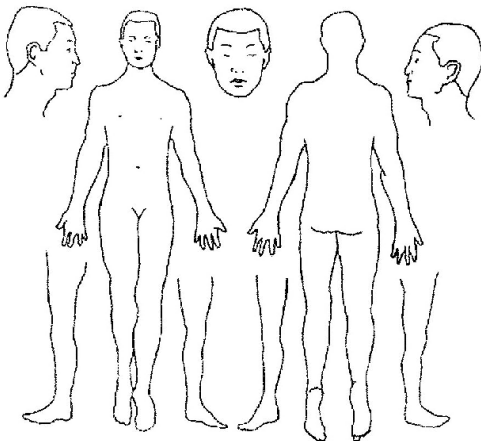
Lunch: _____

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

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

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 |



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- 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

Skin

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

Neuro-Muscular

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Lymphatic System/Accumulated Dampness

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

Liver/Gall Bladder Function

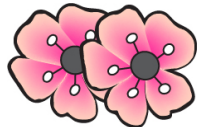
- Headaches
- Migraines
- Pain in ribcage
- Gall stones
- Chronic neck or shoulder tension

Eyes

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

Urinary

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



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Reddish color

Male

- | | | |
|---|---|---|
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Testicular pain/swelling | <input type="checkbox"/> Ejaculation problems |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Erectile dysfunction/impotence |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Infertility | <input type="checkbox"/> Difficulty maintaining an erection |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Poor sperm motility | <input type="checkbox"/> Irregular sperm morphology |
| <input type="checkbox"/> Feeling of coldness or numbness of genitalia | <input type="checkbox"/> 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.)?

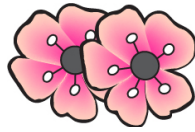
Have you sought medical intervention for these problems? If so, when? _____

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

Client Signature Date

ND, LAc

Reviewed by Date



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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.

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 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

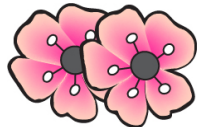
I authorize Catawba Natural Healing to release information necessary for external and internal quality improvement activities including information required by regulatory and accrediting bodies. As described in the Notice of Privacy Practices, Catawba Natural Healing may allow health care providers to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

Financial agreement

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.

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

First visit: 90 minutes for \$155

Follow-up visits: charge \$105 by the hour. If visit is longer than an hour, it's round to the nearest 15-minutes increment.

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.

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 curtesy, 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.