150 Preston Executive Dr. #101 Cary, NC 27513
919-650-1789 carolinanaturalmedicine.com

PATIENT PROFILE DATE: _____

Last Name _____ First Name _____

S.S.N: _____ Birthdate _____ Sex _____

Address _____ City / ST / Zip _____

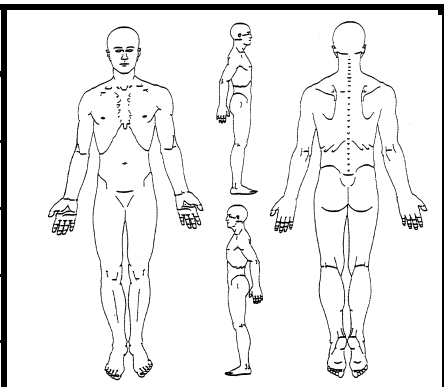
Email _____ Phone: (H) _____(C) _____

Note to our patients: Please complete this 2-sided questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written

PRESENT HEALTH CONCERNS

Indicate painful or distressed areas:

Please list most important health concerns in order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	



What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic physician, and acupuncturist, a nutritionist, a chiropractor or a cou

PLEASE CIRCLE ALL THAT APPLY

Do you have any questions about our clinic or the care that you've chosen today? _____

_____

Please list prescription medications you are currently taking, with dosages (if possible):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list vitamins, minerals, herbs, homeopathic remedies you are currently taking, with dosages (if possi

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

Explain: _____

Personal Habits

Please circle any of the following substances that you use regularly **Tobacco** **Coffee/black tea/soda**
Alcohol **Recreational drugs**

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? **YES** or **NO** (circle one) What type? _____

How long? _____ How often? _____

Past Medical History

Hospitalizations: _____

_____

Serious Illnesses and injuries: _____

_____

Date of last physical / annual exam: _____ Date of last blood tests: _____

Personal and Family History

Please check the "YES" box next to each condition that applies to you or one of your family members. Please note whether the condition applied to you or your family member in the past by denoting a "P for past or "C" for current. Indicate the relationship or the word "Self" in the relationship column.

CONDITION	YES	RELATION	PAST (P) CURRENT (C)	CONDITION	YES	RELATION	PAST (P) CURRENT (C)
Alcoholism / Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list ages: _____

How did you hear of us? _____

Patient Name:_____Date of birth:_____Date of service:_____
Please place a check if you have had any of the following concerns in the past 3 months:

General
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss; how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

Skin
- ❑ Redness
- ❑ Rashes
- ❑ Nodules/bumps
- ❑ Eczema
- ❑ Hair loss/thinning
- ❑ Weak nails

Eyes and Ears
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Blurred/Double vision
- ❑ Ringing in ears
- ❑ Loss of hearing

Nose and Throat
- ❑ Sinusitis
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Obstruction
- ❑ Post nasal drip

Mouth
- ❑ Canker sore
- ❑ Metallic/abnormal taste
- ❑ Dental work

Heart and Lungs
- ❑ Wheezing
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

Nervous System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Paralysis

Kidney/Bladder
- ❑ Frequent or painful urination
- ❑ Urgency
- ❑ Incontinence
- ❑ Blood in urine

Physician Signature:

Blood and Lymphatic
- ❑ Easy bruising
- ❑ Anemia
- ❑ Enlarged lymph node

Bones Joints and Muscles
- ❑ Trauma
- ❑ Pain (neck, low back or other)
- ❑ Arthritis
- ❑ Swelling

Stomach and Intestines
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellowing of the skin
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Anal itching

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Changes in mood
- ❑ Drug/alcohol abuse

Sexual History
- ❑ Gonorrhea
- ❑ Chlamydia
- ❑ Herpes
- ❑ HPV
- ❑ Other

Men Only
- ❑ Erectile dysfunction
- ❑ Testicular pain, swelling or bumps
- ❑ Decreased urinary stream

Women Only
- ❑ Abnormal pap smear
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Heavy periods
- ❑ Fibroids
- ❑ PMS
- ❑ Age of first menses
- ❑ Currently pregnant
- ❑ Birth control

Physician Notes:

- ❑ G:P:A:_____

Physician Notes:

Date:

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your physician and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders/text message, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are
not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us the authorization to contact you with these reminders and information and to leave a message on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time: however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information, and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective, as of _____. This authorization will expire seven years after the data on which you last received services from us.

I authorize you to use or disclose my health information in manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

X_____ X_____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Print Personal Representative Signature

Description of personal representative's authority to act for the patient.

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Informed Consent for Treatment

I _____, hereby authorize the practitioners of the Carolina Clinic of Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis, and treatment.

Common diagnostic procedures: e.g. venipuncture, PAP smears, laboratory, physical exam etc.
Minor office procedures: dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition and nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcohol tinctures, capsules, tablets, creams, plaster or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Counseling: talk therapy.
Acupuncture: application of needles into the body to stimulate and balance energy flow.
Cupping: Application of suction to the skin
Hydrotherapy: application of hot and/or cold to the body.
Massage: manipulation of the soft tissues.
Chiropractic manipulation: adjustments to the spine or extremity.
Therapeutic Exercises: Application of rehabilitative exercises
Colon Hydrotherapy: removing waste and toxins from the large intestine.
Lymphatic Drainage Therapy: therapeutic abdominal massage to promote detoxification.

I recognize the potential risks and benefits of these procedures as described below.
Potential risks: allergic reactions to or side effects of prescribed herbs and or nutritional supplements, inconvenience of lifestyle changes, injury from venipunctures or other office procedures. Potential risk of adjusting or manipulative procedures include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.
Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Carolina Clinic of Natural Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that the Carolina Clinic of Natural Medicine will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that my practitioner to the best of his/her ability will answer any questions I have.

Signature of Patient or Guardian X_____ Date _____
Printed name or Patient or Guardian _____

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Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to review to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by email.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organization. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke authorization
You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information)

Print Patient Name _____

Patient Signature X_____ Date_____

Authorized Provider Representative Signature X_____

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Carolina Clinic of Natural Medicine **Payment and Appointment Policy**

Payment is expected at the time of service. The clinic accepts: cash, check, and credit card forms of payment (Visa, MasterCard, Discover, and American Express). Any recommended supplements are an additional cost, and will NOT be dispersed without payment.

Insurance Billing
The Carolina Clinic of Natural Medicine will be happy to provide you with a superbill to which may be submitted to your insurance company,

I understand that I am responsible, and **agree to pay** for services offered to me by the Carolina Clinic of Natural Medicine, including any remaining portions not covered by my insurance plan. This includes denied coverage, co-pays, and deductibles that need to be met prior to coverage If balance is not paid, accounts will be submitted to our collection agency.
X_____ Print Patient Name _____

Appointments
Your scheduled appointment time is being held for you, and is a commitment. In our efforts to continuously improve our patient service and office efficiency the credit card number below will secure your first scheduled office appointment, and any future scheduled office appointments for service. The credit card number below will be charged for all NO SHOW AND CANCELLED appointments without a 24-hour notice form you. The charges are as follows: First office visit $150.00, Weekday office visit $50.00 and Saturday office visit $85.00.
X_____ Print Patient Name _____

Credit Card on file
I authorize Carolina Clinic of Natural Medicine to charge outstanding patient portion balances, supplements, and cancellation fees for my dependents and myself to the following credit card:

Credit Card Number _____/_____/_____/_____
Expiration date _____/_____ Signature Code_____ Billing Zip Code_____
Name on Credit Card: _____

Signature X _____Date_____

I acknowledge that I have read and understand the above information. Initials _____