Charlotte Natural Wellness
10722 Carmel Commons Blv
Suite 450, Charlotte, NC 28226
ph: (704) 543-5540

CHILD HEALTH HISTORY FORM

Date of 1st Appointment ____________

Name____ Gender M___ F___ Birth Date _____________ Age_____

Name your child likes to be called_________________________ Height ____ft _____ in Weight _________ pounds

Address ______________________________________ City _______________________State _____ Zip ____________

Mother's Name ___________________________________email : _______________________Birth Order:____________

Home Phone____________________ Work Phone ____________________ Mobile Phone ______________________

Father's Name___________________________________ email: _______________________ Birth Order:____________

Home Phone____________________Work Phone ____________________ Mobile Phone ______________________

How did you learn about Dr. Michelle and Charlotte Natural Wellness? Check those that apply: ☐Google Search, ☐NCANP website, ☐Facebook, Or Other : _____________________________________

Please list your current health concerns that you would like addressed:

____

____

____

Has your child ever received health care or treatment from a:

☐ Naturopathic Physician ☐ Acupuncturist ☐ Other "Natural Practitioner"

Please check any that have been a problem for a parent, grand-parent, sister, brother, aunt or uncle:

☐ cancer	☐ arthritis	☐ kidney disease	☐ thyroid/adrenal
☐ diabetes	☐ stroke	☐ heart problems	☐ high blood pressure
☐ celiacs	☐ epilepsy	☐ asthma	☐ mental disorder
☐ alcoholism / addiction		☐ autoimmune or inherited _________________	

Please check any of the following your child is exposed to:

☐ dust	☐ mold	☐ dampness	☐ fumes
☐ chemicals	☐ paint	☐ solvents	☐ insecticides
☐ varnishes	☐ lacquers	☐ excessive heat	☐ excessive cold

Please UNDERLINE any of the following your child has experienced in the past,

and

Please CIRCLE any which your child currently or has recently experienced:

fear	phobias	nervousness	extreme stress
extreme pain	insomnia	grief	guilt
loneliness	nightmares	irritability	low self-esteem
lack of confidence	angry outbursts	"hyper" behavior	insensitive behavior
compulsiveness	depression/disinterest	trembling	shallow breathing
cold sweats	confusion	difficult concentration	fever
asthma	allergies	skin condition	head injury
bone/joint disease	jaundice	hepatitis	mononucleosis
appendicitis	seizures	headaches	migraines
yeast problems	thrush	diabetes	cancer
broken bones	back pain	neck pain	major injury
unusual change in appetite		unusual change in weight	
food, chemical, or drug poisoning		night sweats	muscle twitching
unusual lumps	enlarged glands	abnormal discharges	abnormal bleeding
dizziness	loss of balance	abnormal sensations	eye pain
tearing eyes	ringing ears	nosebleeds	wheezing
short of breath	chest pain	irregular heart beat	swelling or edema
difficulty swallowing	stomach problems	digestive problems	mouth sores
intestinal disease	bowel problems	food intolerances	kidney problems

urinary symptoms: frequency, urgency, bed wetting, other urinary symptoms

Does your child have any other health problem or condition you wish to mention?

____

____

____

____

____

	YES	NO
Does your child follow any special way of eating?	_____	_____

Please explain: ____

____

____

	YES	NO
Are you aware of your child having any allergies?	_____	_____

Please explain: ____

____

____

	YES	NO
Has your child ever been hospitalized or had surgery?	_____	_____

Please explain: ____

____

____

	YES	NO
Is your child receiving care for their well-being now?	_____	_____

From whom? ____

For what purpose?____

____

____

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, and any other supplements or remedies which your child is using now. Please indicate what s/he is using them for, how much s/he uses, and how long s/he has been using them. Thank You.

What is used	**What it's for**	**How much used**	**How long used**

Thank you for taking the time to complete this form. It will help me to help your child. I look forward to meeting with both of you.

Dr Michelle Dillon

Charlotte Natural Wellness

Improving Health Without Drugs or Surgery

Naturopathic Medical Legal Disclosure

This is to inform you of the legalities of North Carolina and Naturopathic Medicine.

- The state of North Carolina does not offer a Naturopathic Medical License to Naturopathic Physicians. Dr. Dillon currently maintains her Naturopathic Medical license in the state of Vermont. (Vermont License Number: 099-0000234)

  _________ **Initial**

- As a result, Dr. Dillon cannot prescribe any pharmaceutical medications, perform and minor surgeries, administer injections, or diagnose any illnesses.

  __________ **Initial**

- Dr. Dillon is trained as a primary care physician; however, in the state of North Carolina, she is not able to fulfill that role. Therefore she needs you to maintain a relationship with your primary care physician.

  __________ **Initial**

Print Name: ____

Sign Name: ____ **Date:** _______________

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Missed Appointment/Cancellation Policy

Thank you again for choosing Charlotte Natural Wellness. We appreciate and value the privilege of serving you.

We have found it is best to be sure that everyone is clear about appointment and payment policies before their first appointment. The policies are simple. This note is to insure your understanding. If you have any questions or concerns please call Charlotte Natural Wellness and we will answer them for you.

We regret that past experience has made this policy necessary.

I understand that in order to maximize my results with Naturopathic care, I must be on time or early for my appointments.

I also understand there is a $150.00 fee for each missed appointment. __________ **(Please Initial)** This includes any and all appointments made by me, including spouse, or children.

Additionally, I understand that I must give a **49 hour notice** if I need to cancel or reschedule my appointment. I understand that I will be charged $150.00 for any missed appointments/cancellations with less than **49 hours notice**, in accordance with the office Missed Appointment/Cancellation policy.

I agree to the above terms and conditions.

Print Name: ____

Sign Name: ____ **Date:** ________________

FINANCIAL AGREEMENT AND CREDIT CARD AUTHORIZATION

I agree to the above mandatory cancellation fees. I authorize Charlotte Natural Wellness, Inc. to charge the card below in accordance with the cancellation policy at any time.

Patient Name: -

____

Name on Card:

____

Card Number:

____

Expiration Date: ____________ Security Code: __________ Billing Zip Code: ___________

**This and all private credit card information is kept secure and encrypted. The original document will be shredded after being digitally recorded.

Signature: ____ Date: _______________