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

ADULT HEALTH HISTORY FORM

Date of 1st Appointment. ____________

Name ________________________________ Gender: M ___ F ___ Birth Date ______________ Age _____

Name you wish to be called _______________ Marital Status: _________ Height _______ Weight _______

Address ___________________________________ City ____________________ State _____ Zip _________

Home Phone _________________ Work Phone _________________ Mobile Phone _________________

Email Address ______________________ Birth Order ___________________________

Education ________________ Occupation _________________________ Position _______________

Who is the nearest relative or friend who you would like to have called in case of an emergency? Name Relationship: 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:

____

____

____

Have you ever been to a ☐ Naturopathic Physician ☐ Acupuncturist ☐ Other “Natural Practitioner”

Do you have a pacemaker, artificial heart valve, or any artificial device in your body? ☐ Yes ☐ No

If yes, please describe: ____

What is your level of mental stress? ☐ low ☐ moderate ☐ high

What is the pace of your work? ☐ slow ☐ medium ☐ fast

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

☐ cancer ☐ diabetes ☐ stroke ☐ heart problems ☐ high blood pressure

☐ arthritis ☐ celiacs ☐ mental disorder ☐ alcoholism/addiction ☐ thyroid/adrenal

☐ asthma ☐ epilepsy ☐ kidney disease ☐ autoimmune or inherited ________________

Please check any of the following you are exposed to:

☐ dust ☐ mold ☐ dampness ☐ fumes

☐ chemicals ☐ paint ☐ solvents ☐ insecticides

☐ varnishes ☐ lacquers ☐ excessive heat ☐ excessive cold

What is your current energy level? (1=low; 5=high) ☐1 ☐2 ☐3 ☐4 ☐5

Do you have any contagious disease? ☐Yes ☐No If yes, please describe:

____

Are you receiving any care for physical well-being now? If so from ____________________

whom? For what purpose? ____

Are you receiving any care for emotional well-being now? If so from ____________________

whom? For what purpose? ____

Are you happy now? Yes No What fosters or prevents your happiness now?

____

____

____

Please rate the quality of the following different parts of your life (1=low; 5=high):

Family	☐1	☐2	☐3	☐4	☐5
Friends	☐1	☐2	☐3	☐4	☐5
Romance/relationship(s)	☐1	☐2	☐3	☐4	☐5
Spirituality	☐1	☐2	☐3	☐4	☐5
Health	☐1	☐2	☐3	☐4	☐5
Recreation/fun	☐1	☐2	☐3	☐4	☐5
Career	☐1	☐2	☐3	☐4	☐5
Financial	☐1	☐2	☐3	☐4	☐5
Physical Environment					
___Where you live	☐1	☐2	☐3	☐4	☐5
___Where you work	☐1	☐2	☐3	☐4	☐5
___Other	☐1	☐2	☐3	☐4	☐5

Yes	No	Please answer the next 11 lines with a Yes, No, Number or Date				
		Are you pregnant now?				
		Age at 1st menses:				
		Last menses date:				
		Length of cycle (monthly):				
		Days of flow (menses):				
		Number of pregnancies:				
		Number of live births:				
		Number of miscarriages:				
		Number of abortions:				
		Last PAP/exam date:				
		Do you do breast self-exams?				

Please return to checking the **Past** or **Now** columns again

Past	**Now**	Please leave this space blank.				
		Fainting				
		Dizziness or vertigo				
		Loss of memory				
		Paralysis				
		Epilepsy or Seizures				
		Numbness or tingling				
		Muscle weakness				
		Parkinson's				
		Multiple sclerosis				
		Neurological disorder				
		Acne or boils				
		Skin color changes				
		Dry Skin				
		Oily Skin				
		Eczema				
		Hives				
		Rash				
		Itching				
		Other skin condition				
		Chronic infections				
		Ongoing infections				
		Allergy - food				
		Allergy - environmental				
		Mold sensitivity				
		Candida/yeast infections				
		Swollen or enlarged glands				
		Lumps or tumors				
		Cancer				
		Vaccine reactions				
		Slow wound healing				

Past	**Now**	Please leave this space blank.				
		Chronic pain				
		Mental / emotional problems				
		Extreme stress				
		Anxiety or Nervousness				
		Depression				
		Suicide plan(s)				
		Suicide attempt(s)				
		Mood swings				
		Irritability				
		Frequent crying				
		Lack of confidence				
		Low self-esteem				
		Fear				
		panic				
		Grief				
		Guilt				
		Shame				
		Loneliness				
		Mental confusion				
		Compulsiveness				
		Eating disorder				
		Concentration difficulties				
		Insomnia				
		Heavy metal poisoning				
		Food poisoning				
		Chemical poisoning				
		Toxic exposure				
		Cold sweats				
		Major injury				
		Extreme pain				
		Chronic fatigue				
		Weight change				
		Abnormal bleeding				
		Abnormal discharges				
		Swelling / edema				
		Unusual lumps				
		If you have any other health				
		issues please list them here:				

Please **CHECK** any below that is true or a yes .

- ☐ Were you raised by both parents? If not, who raised you? ___________
- ☐ Did you receive kindness, love, and attention from them?
- ☐ Did you do things together just for fun?
- ☐ Did you get along well with:
  - ☐ your parent(s) or guardian?
  - ☐ our sibling(s)?
  - ☐ your schoolteachers?
  - ☐ your classmates?
- ☐ As a child did anyone in your family have a problem with alcohol, drugs, or addictions?
- ☐ Was anyone mentally or physically abusive?
- ☐ Was there a particular family member who was especially kind and loving?
- ☐ Were you happy as a child?
- ☐ Are you happy now?
- ☐ Have you been married more than once?
- ☐ Do you get along well with your partner?
- ☐ Do you enjoy being with your partner?
- ☐ Do you do things together just for fun?
- ☐ If you have children, what are their ages?

  ____
- ☐ Do you get along well with all of them?
- ☐ Do you enjoy being with all of them?
- ☐ Do you do things together just for fun?
- ☐ How many people live in your house?______
- ☐ Have you or has anyone in your home
  - ☐ been mentally or physically abusive?
  - ☐ been addicted to drugs or alcohol?
  - ☐ been especially kind & loving to you?

- ☐ Are you kind and loving to your family and friends?
- ☐ Do you do something daily for your own enjoyment?
- ☐ Do you spend significant time outside?
- ☐ Do you have hobbies or similar interests? please list _________________________________
- ☐ Do you enjoy your work?
- ☐ Do you have more than one job?
- ☐ How many hours do you work weekly?_____
- ☐ Do you get along well with
  - ☐ your employer?
  - ☐ our fellow employees?
  - ☐ people you supervise?
  - ☐ your friends?
- ☐ Do you consider your health to be good? Do you:
  - ☐ exercise regularly?
  - ☐ awaken rested?
  - ☐ have regular bowel movements?
  - ☐ have a satisfactory sex life?
  - ☐ have a vacation each year?
  - ☐ watch TV? - how much? ________
  - ☐ drink alcohol - how much?_______
  - ☐ use recreational drugs? how often_____
  - ☐ drink coffee - how much? _________
  - ☐ use birth control?
    - ☐ pills
    - ☐ other
  - ☐ use tobacco?

    how much_______ how long _________

☐ Are you aware of having allergies?
Please list: ____________________

☐ Do you follow any special way of eating? Please describe: ____________________

☐ Have you ever been hospitalized or had surgery? Please explain: ____________________

☐ Do you have a significant religious or spiritual focus? If yes please describe: ____________________

☐ Do you do any form of stress management? If yes please describe: ____________________

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, and any other supplements or remedies which you are using now. Please indicate what you are using them for, how much you use, and how long you have been using them. Thank You.

What you use	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 you. I look forward to meeting with you.

Dr. Michelle Dillon, ND

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:** _______________

Charlotte Natural Wellness

Improving Health Without Drugs or Surgery

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: _______________