Glenn Ingram, Jr, ND
Marty Ingram, ND

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1 Market Street
Brevard, NC 28712

Phone: 828-233-5576
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Name ________________________________ **Today's Date** ________________

Parent/Guardian Name(s): ________________________ **Relationship** ________________

Age __________ **Date of Birth** ___/___/___ **Gender:** □ Female □ Male **Social Security #**________________

Address ________________________________ **City/State/Zip** ________________________

Guardian Phone # (Home) ________________ (Work) ________________(Cell) ________________

At which phone number(s) may we leave voice mail messages? ________________

E-mail ________________________________

Guardian Occupation ________________________ **Employer** ________________________

Emergency Contact ________________ **Emergency Contact Phone** ________________________

Primary Care Physician ________________________ **PCP Phone** ________________________

How did you hear about us? ____

Referred by a doctor? □ Yes □ No **Who?** ________________________________

May we contact you via e-mail for feedback, updates, and newsletters? □ Yes □ No

What are your goals for your child's health care?________________________________

Briefly describe your child's current health concern.________________________________

____

____

What are your most important health concerns? List in order of importance?

1. ____
2. ____
3. ____
4. ____
5. ____

When was the last visit to a doctor? ________ **For?** ________________________________

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, homeopathic remedies, herbs, vitamins, or other supplements you are taking along with dosage amounts?

____

____

____

____

ALLERGIES

Are you hypersensitive or allergic to... **□ No Known Allergies**

Any drugs?____________________________________ **Any foods?** ____________________________________

Anything in the environment? _________________________________ **□ Tape/Adhesives** **□ Latex**

GENERAL

Weight _____lbs. **Height/Length** ________ **Head Circumference (if applicable)**_________

PAST MEDICAL HISTORY

Surgeries or Hospitalizations: ____

____

Major Illnesses: ____

____

Have a history of abuse? □ Y □ N **Head injuries?** □ Y □ N

FAMILY HISTORY

Do you have a family history of any of the following? Check all that apply.

□ Diabetes □ Heart Disease □ Cancer □ Autoimmune Disease □ Allergies □ Mental Illness

Other: ____

Is there a family history of your current complaints? □ Y □ N **Which ones?** _____________________________

REVIEW OF SYSTEMS

Check all that apply. Y **= Yes, I have this now** P **= In the past** N **= Never had**

MENTAL/EMOTIONAL

Mood Swings? □ Y □ P □ N
Anxiety or nervousness? □ Y □ P □ N
Depression? □ Y □ P □ N
Poor concentration? □ Y □ P □ N
Memory problems? □ Y □ P □ N
Fatigue? □ Y □ P □ N

HEAD

Headaches? □ Y □ P □ N
Hair Loss? □ Y □ P □ N

EARS

Earaches? □ Y □ P □ N
Impaired hearing? □ Y □ P □ N
Dizziness? □ Y □ P □ N
Ringing? □ Y □ P □ N

EYES

Loss of vision? □ Y □ P □ N
Pain/irritation? □ Y □ P □ N
Redness? □ Y □ P □ N

NOSE AND SINUSES

Nose Bleeds? □ Y □ P □ N
Stuffiness? □ Y □ P □ N
Hayfever? □ Y □ P □ N
Loss of smell? □ Y □ P □ N

MOUTH AND THROAT

Frequent sore throat? □ Y □ P □ N
Sore tongue/lips? □ Y □ P □ N

CARDIOVASCULAR

Heart disease? □ Y □ P □ N
High/Low Blood Pressure? □ Y □ P □ N
Palpitations/Fluttering? □ Y □ P □ N
Bleed easily? □ Y □ P □ N

RESPIRATORY

Cough? □ Y □ P □ N
Wheezing? □ Y □ P □ N
Asthma? □ Y □ P □ N
Bronchitis? □ Y □ P □ N

GASTROINTESTINAL

Heartburn? ☐ Y ☐ P ☐ N
Belching or passing gas? ☐ Y ☐ P ☐ N
Change in thirst? ☐ Y ☐ P ☐ N
Change in appetite? ☐ Y ☐ P ☐ N
Constipation? ☐ Y ☐ P ☐ N
Diarrhea? ☐ Y ☐ P ☐ N
Bowel Movements
How often? ____________________

URINARY

Increased frequency? ☐ Y ☐ P ☐ N
Frequent infections? ☐ Y ☐ P ☐ N
Difficulty starting? ☐ Y ☐ P ☐ N
Pain? ☐ Y ☐ P ☐ N

MUSCULOSKELETAL

Joint pain or stiffness? ☐ Y ☐ P ☐ N
Arthritis? ☐ Y ☐ P ☐ N
Muscle spasms or cramps? ☐ Y ☐ P ☐ N
Injuries? ☐ Y ☐ P ☐ N

SKIN

Rashes, Acne, Boils? ☐ Y ☐ P ☐ N
Itching? ☐ Y ☐ P ☐ N

IMMUNE

Vaccinations? ☐ Y ☐ P ☐ N
Any problems with vaccines? ☐ Y ☐ N
Chronic infections? ☐ Y ☐ P ☐ N
Chronically swollen glands? ☐ Y ☐ P ☐ N
Slow wound healing? ☐ Y ☐ P ☐ N

ENDOCRINE

Thyroid problems? ☐ Y ☐ P ☐ N
Heat or cold intolerance? ☐ Y ☐ P ☐ N
Hypoglycemia? ☐ Y ☐ P ☐ N
Diabetes? ☐ Y ☐ P ☐ N

LIFESTYLE AND HABITS

Get plenty of exercise? ☐ Y ☐ P ☐ N
Participate in sports? ☐ Y ☐ P ☐ N
If yes, what kind? ______________________________
How often? ______________________________
Sleep well? ☐ Y ☐ P ☐ N
Spend time outside? ☐ Y ☐ P ☐ N
How many hours of television? _______________
How many hours do you read? _______________
Attend School? ☐ Y ☐ P ☐ N
How often? ______________
What grade? _____________
Do you eat 3 meals a day? ☐ Y ☐ P ☐ N
Family have a spiritual practice? ☐ Y ☐ P ☐ N
Describe ______________________________
Does anyone smoke tobacco? ☐ Y ☐ P ☐ N
How much? ______________________________
Use recreational drugs? ☐ Y ☐ P ☐ N
Which ones? ______________________________
How much? ______________________________
Does anyone drink alcohol? ☐ Y ☐ P ☐ N
How much? ______________________________
Hobbies? ______________________________
Other interests ______________________________

Is there anything you would like to add? ______________________________

____

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Welcome! I'm happy to help you; if you have any questions, just ask.

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Financial Policy and Fee Schedule

(Effective January 2013)

It is our hope you will understand our financial policies are a necessary part of assuring the resources required to maintain our unique health care services for our patients and the community.

BILLING POLICY:

- **All payments are due in full at the time of service.** We are a fee-for-service office. If you are not prepared to pay, we will need to reschedule your appointment or make other arrangements.
- We accept Cash, Check, Debit, or Credit card.
- A $25.00 fee will be charged to your account for all returned checks plus any bank fee charges.
- **We do not accept or submit health insurance claims for payment.** Naturopathic medicine is not covered by health insurance in the state of North Carolina at this time.

FEE SCHEDULE:

The following fees are for office visits only, and do not include the cost of any medicinary items or lab testing. Discounts are available for students and low income patients. The fees charged take into account the time, skills and professional component required for each visit and procedure. They are comparable to fees charged in this and neighboring communities by other competent doctors.

- 15-minute informational interview — free
- Extensive new patient visit — $180 ($150 for children 12 and under)
- Return visits
  - Brief — $40
  - Intermediate — $60
  - Standard — $80
  - Extensive — $110

We welcome your questions, and any brief phone call or email clarifying your existing treatment plan is free of charge.
Any phone call or email that covers new material or takes an extensive amount of time will be billed as an office visit.

Ask about our **Family Plan** if you have several people in your household who would like to come and see us.

DELINQUENT ACCOUNTS:

Accounts exceeding 60 days past due from the date of service are considered delinquent.

At the discretion of the office manager, all accounts 90 days are delinquent and will be referred to an outside collection agency. **A $50.00 collection fee will be charged if the account is placed with an outside agency**. We will be unable to see you until the account is paid in full.

CANCELLATION POLICY:

You must notify the office 48 hours prior to canceling or rescheduling your appointment. We reserve the right to charge a $35 fee for cancellations made less than 2 business days before your scheduled appointment.

I understand and agree that I am responsible for payments to Through the Woods Natural Health for charges to my account. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses including reasonable attorney fees.

________________________________ Signature

________________ Date

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Disclosure and Informed Consent

I, ____(client name) request, authorize and consent to a program of naturopathic services to be performed by Through the Woods Natural Health.

I understand that Glenn Ingram, Jr, ND and Marty Ingram, ND are not medical doctors and are not licensed in the State of North Carolina, as the State of North Carolina does not presently recognize qualified, naturopathic physicians. We do hold licenses in another state that recognizes naturopathic doctors. It is therefore understood that Glenn Ingram, Jr, ND and Marty Ingram, ND do not diagnose and treat any disease and/or condition, but rather offer an alternative approach to the client for the condition(s) presented. The services to be provided by Through the Woods Natural Health are not meant to replace medical care by a licensed medical provider; it is the responsibility of the client to obtain all appropriate tests and evaluations by their primary care physician and/or specialist.

I have been notified of the Notice of Use of Private Health Information from Through the Woods Natural Health, posted on our website (http://www.throughwoods.com/New%20Patient) and in our office, in accordance with *The Standards for Privacy of Individuality Identifiable Health Information* ("Privacy Rule") established by The US Department of Health and Human Services to implement the requirement of the Health Insurance Portablility and Accountability Act of 1996 (HIPAA). I have also been given the opportunity to have any questions regarding this notice answered by my health care provider or staff, as well as the appropriate contact information to the Office of Civil Rights.

____	____________________
Signature	Date