The Naturopathic Wellness Center
At Integrative Medical Clinic of Santa Rosa
Moses Goldberg, ND

NOTE: Please bring in all prescription medications, vitamins, supplements or herbs that you are currently taking to your first office visit. Please bring these in the original bottle.
Current (3-6months) laboratory testing data is also beneficial to bring to appointment

OFFICE POLICIES AND CONSENT TO NATUROPATHIC HEALTH COUNSELING:
These office policies have been created to better serve you. Please read the following and sign the bottom

Appointment Fees:

Adults: The initial visit is generally 60 to 90 minutes and cost is $345.00 – $395.00
Follow up visits will average 30 - 50 minutes and cost is $145.00 – $185.00.
Children (12 and under): The initial visit will cost $245; follow up visits will be $145.00-$185.00.

House calls are a welcomed service with an additional $50 fee.

Telephone conversations *more* than 5 minutes will be billed at session fees.

Payment is due at the time of services – cash, check, Visa or MasterCard. You will be charged an additional $30 if the check is returned. If you have insurance, we can generate a bill for you to submit to your carrier for possible reimbursement. Please inquire at the front desk upon arrival to appointment.

Those with Medicare Part B Insurance coverage:

If you have a current referral to Moses Goldberg or Dana Michaels from Drs. Dozor or Barnett, then payment is not due at time of service and will be processed through your current Medicare Part B coverage. This referral is valid for up to 3 months.

Cancellation:

You may be charged for a missed appointment or late cancellation if you do not provide 48 hours' notice. Please be respectful that your appointment is time reserved for you. The practice is usually booked out 1 – 2 weeks ahead of schedule.

Moses Goldberg, ND, is an independent practitioner at IMC. As a patient of Dr. Goldberg's, you agree to indemnify and hold IMC harmless of any liability you feel arises during your visit or by subsequent counseling.

I have read, understand and agree to the above office policies.

Print Name: _____ Date: _____

Signature: _____

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Patient Name: _____ **DOB:** _____

Would you like to receive The Naturopathic Wellness Center eNewsletter? Y N

Email: _____

In Order of importance, list your health issues:

1) _____
2) _____
3) _____
4) _____
5) _____

Last time you had blood work done and with what physician?

_____

Family History:

	Mother	Father	Siblings	Grandparents	Children
Age if living					
Age when died: Reason for death:					
Cancer: Specify type:					
High Blood Pressure:					
Heart Attack/Stroke:					
Heart Disease:					
Asthma/Allergies:					
Mental Illness:					
Tuberculosis (TB)					
Auto-Immune Disease:					
Diabetes Mellitus:					
Osteoporosis:					

List All Surgeries & Hospitalizations, including date occurred:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please note when you have had each of the following:

X - Rays: _____
MRI / Cat Scans: _____
Ultrasounds: _____
Accidents: _____
TB Test: _____
HCV: _____
HIV Test: _____
Last Eye Exam: _____
Colonoscopy: _____
Last Dental Visit _____

Dr. Moses Goldberg ◆ Naturopathic Wellness Center
@ Integrative Medical Clinic of Santa Rosa
175 Concourse Boulevard ◆ Santa Rosa, California 95403 ◆ P: 707.284.9200 ◆ F: 707.284.9204

New Patient Intake Form

Have you had the Disease (D), Vaccination (V) or Neither (N)? Circle:

Measles: D V N Chicken Pox: D I N Mumps: D I N German Measles: D V N

Whooping Cough: D V N Rubella: D V N Tetanus: D V N Hemophilus/Hib: D V N

Hepatitis B: D V N Any vaccination reactions: _____

List Yes (Y), No (N) or in the Past (P) regarding use of the following: Circle:

Antacids: Y N P Steroids: Y N P Pain Relievers: Y N P Laxatives: Y N P

Coffee: Y N P If Y/P How many cups per day? _____

Soda: Y N P How much per day? _____ Drink diet sodas? _____

Smoking: Y N P Packs per day? _____ For how many years? _____

Alcohol: Y N P How often & how much if Yes/Past? _____

Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P Family history of addiction? Y N

Recreational Drugs: Y N P Which ones?_____

Any Drug Addictions: Y N P Any Drug Treatment: Y N P

List all Prescription Medicines, include dosages: (Remember to bring the bottles with you)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Nutrient Supplements and Herbs, include dosages: (Remember to bring the bottles with you)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Review of Systems: **List Yes (Y), Past (P), or leave blank if never had the issue.**

SKIN			
Rash:	Y P	**Color Change:**	Y P
Hives:	Y P	**Lump:**	Y P
Psoriasis/eczema:	Y P	**Itchy:**	Y P
Dry:	Y P	**Warts/moles:**	Y P
Cancer:	Y P	**Perspiration:**	Y P
HEAD			
Headache:	Y P	**Migraine:**	Y P
Dandruff:	Y P	**Head Injury:**	Y P
Oil/dry hair:	Y P	**Hair loss:**	Y P

NOSE			
Frequent Colds:	Y P	**Nosebleeds:**	Y P
Congestion:	Y P	**Post Nasal Drip:**	Y P
Polyps:	Y P	**Seasonal Allergies:**	Y P

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EYES			
Dry/Watery:	Y P	**Blurry Vision:**	Y P
Double Vision	Y P	**Cataracts:**	Y P
Glaucoma:	Y P	**Styes:**	Y P
Strain:	Y P	**Discharge:**	Y P
Itchy:	Y P	**Dark under Eyelid:**	Y P
MOUTH/THROAT			
Canker sores:	Y P	**Cold sores:**	Y P
Sore Throat:	Y P	**Gum disease:**	Y P
Dentures:	Y P	**Cavities:**	Y P
Loss of taste:	Y P	**Hoarseness:**	Y P
NECK			
Stiffness:	Y P	**Swollen Glands:**	Y P
Full movement:	Y P	**Tension:**	Y P
RESPIRATORY			
Cough:	Y P	**TB:**	Y P
Shortness of breath w/ exertion:	Y P	**Bronchitis:**	Y P
Shortness of breath sitting:	Y P	**Pneumonia:**	Y P
Shortness of breath lying down:	Y P	**Asthma:**	Y P
Wheezing:	Y P	**Painful breathing:**	Y P
CARDIOVASCULAR			
High Blood Pressure:	Y P	**Rheumatic Fever:**	Y P
Low Blood Pressure	Y P	**Murmurs:**	Y P
Arrhythmias:	Y P	**Palpitations:**	Y P
Edema:	Y P	**Chest Pain:**	Y P
URINARY TRACT			
Incontinence:	Y P	**Pain w/ Urination**	Y P
Frequent Infections:	Y P	**Kidney Stones**	Y P
Urgency:	Y P	**Discharge/Blood:**	Y P
GASTROINTESTINAL			
Heartburn:	Y P	**Bowel Movement Frequency**	_____
Indigestion:	Y P	**Recent BM Change:**	Y P
Bloating:	Y P	**Diarrhea/Constipation:**	Y P
Nausea:	Y P	**Blood in Stool**	Y P
Vomiting:	Y P	**Often Passing Gas**	Y P
Change in Appetite:	Y P	**Gall Bladder Disease**	Y P
Pancreatitis:	Y P	**Ulcer**	Y P
Liver Disease:	Y P	**Hemorrhoids:**	Y P
MALE GENITALIA			
Testicular pain/swelling:	Y P	**Sexually Active:**	Y P
Hernia:	Y P	**S.T.D.:**	Y P
Impotency:	Y P	**Sexual Orientation:**	Hetero Homo Bi
Discharge:	Y P	**Prostate Disease/Symptoms:**	Y P

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FEMALE GENITALIA			
Age Period Began: _____		**How many days is your cycle?** _____	
How many days does period last: _____		**Heavy menstrual bleeding:**	**Y P**
Menstrual cramping:	**Y P**	**Menstrual**	**Y P**
PMS:	**Y P**	**Food cravings**	**Y P**
Number of Pregnancies: _____ **Miscarriages:**_____ **Live Births:**_____ **Abortions:**_____			
Last Pap Smear: _____		**Sexual Orientation:** **Hetero Homo Bi**	
Any abnormal Paps:	**Y P**	**When was it abnormal:** _____	
Menopausal since what age: _____		**Use of Hormones:**	**Y P**
Low Libido	**Y P**	**Which hormones used?** _____	
Sexually Active:	**Y P**	**Dry vagina:**	**Y P**
Vaginitis:	**Y P**	**Pain w/ Intercourse:**	**Y P**
S.T.D.:	**Y P**	**Mammography:**	**Y P**
Dexa Scan:	**Y P**	**If Yes, what were results:**	
Please list any birth control used and at what ages:			
Do you perform monthly self-breast exams? Y N			
Do you want instructions on the correct procedures of self-breast exams? Y N			

MUSCULOSKELETAL			
Weakness:	**Y P**	**Arthritis:**	**Y P**
Stiffness:	**Y P**	**Leg Cramps:**	**Y P**
Tremors:	**Y P**	**Pain:**	**Y P**
NERVOUS			
Paralysis:	**Y P**	**Sciatica:**	**Y P**
Tingling/numbness:	**Y P**	**Carpal tunnel syndrome:**	**Y P**
Seizures:	**Y P**	**Fainting:**	**Y P**
Mental/Emotional			
Depression:	**Y P**	**Anger/irritability:**	**Y P**
Suicidal:	**Y P**	**High-strung/tense:**	**Y P**
Anxiety:	**Y P**	**Fear/Panic**	**Y P**
Eating disorder:	**Y P**	**Psych Hospitalization:**	**Y P**

You are doing great, you are almost done!
Weight:_____lbs_ Weight one year ago:_____ Ideal Weight: _____ Height: _____
Energy Level: _____ / 10 (0 = no energy, 10 = lots of energy)
Fatigue: Y N If yes, does it interfere with your daily activity? Y N
Exercise: How often do you exercise? _____
What types of exercise? _____

Sleep:
How many hours? _____ Do you wake up frequently?_____
Nightmares: Y N P Wake Refreshed: Y N P Sleep walk: Y N P Grind teeth: Y N P
Snore: Y N P Sleep aids: Y N P Which ones: _____

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Toxin Exposure:

Did you grow up near any refinery polluted: Y N If so, what kind?

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, nail salons, laundry rooms, gasoline or other vapors?

_____

Do you use pesticides, herbicides or other chemicals around your home?

_____

Social Life:

Would you consider yourself a happy person? _____

Do you enjoy your job: Y N Hours worked per week: _____

Highest Level of Education: _____

Main interests and hobbies: _____

Active spiritual practice: Y N P

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N If so, at what age and by whom? _____

_____

_____

What are your health goals? _____

_____

_____

How committed are you towards making valuable changes? Little Moderately Very

Activity	**Have you ever used:**		**Would like to try:**	
Acupuncture / Chinese Medicine	Y	N	Y	N
Homeopathy	Y	N	Y	N
Massage	Y	N	Y	N
Chiropractic	Y	N	Y	N
Energy work	Y	N	Y	N
Feldenkrais	Y	N	Y	N
Tai Chi / Chi Gung	Y	N	Y	N
Herbal Medicine	Y	N	Y	N
Biofeedback	Y	N	Y	N
Counseling Therapy	Y	N	Y	N
Hydrotherapy	Y	N	Y	N