



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

NOTE: Please bring in all prescription medications, herbs, vitamins & supplements you are currently taking to your first office visit. Please bring these in the actual 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.

Follow up visits will average 30 - 50 minutes and cost is \$135.00- \$195.00.

Children (12 and under): The initial visit will cost \$245; follow up visits will be \$135.00-\$195.00.

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 Dr. Goldberg or Dr. Michaels by Dr. 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 4 visits within 3 months timeframe.

Cancellation:

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

Dr. Moses Goldberg 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. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please note when you have had each of the following:

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

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.

<u>SKIN</u>			
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
<u>HEAD</u>			
Headache:	Y P	Migraine:	Y P
Dandruff:	Y P	Head Injury:	Y P
Oil/dry hair:	Y P	Hair loss:	Y P
<u>NOSE</u>			
Frequent Colds:	Y P	Nosebleeds:	Y P
Congestion:	Y P	Post Nasal Drip:	Y P
Polyps:	Y P	Seasonal Allergies:	Y P

New Patient Intake Form

<u>EYES</u>			
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
<u>MOUTH/THROAT</u>			
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
<u>NECK</u>			
Stiffness:	Y P	Swollen Glands:	Y P
Full movement:	Y P	Tension:	Y P
<u>RESPIRATORY</u>			
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
<u>CARDIOVASCULAR</u>			
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
<u>URINARY TRACT</u>			
Incontinence:	Y P	Pain w/ Urination	Y P
Frequent Infections:	Y P	Kidney Stones	Y P
Urgency:	Y P	Discharge/Blood:	Y P
<u>GASTROINTESTINAL</u>			
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
<u>MALE GENITALIA</u>			
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

New Patient Intake Form

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: _____

New Patient Intake Form

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

<u>Activity</u>	<u>Have you ever used:</u>		<u>Would like to try:</u>	
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