Naturopathic Wellness Center
At Integrative Medical Clinic of Santa Rosa

Dana Michaels, ND

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

Please Bring to Appointment:

- Prescription medications, vitamins, supplements, or herbs in original labeled bottle.
- Recent laboratory results, imaging reports, or referring physician consultation notes.
- This completed packet.

Appointment Fees:

Adults: Initial visit is generally 90-120 minutes at cost of $325.00
Follow up visits will average 45 minutes at cost of $145.00- $185.00 .
Children (12 and under): Initial visit is $245; follow up visits are $145.00.

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

Payment is due at the time of services by cash, check, Visa or Mastercard. You will be charged an additional $30 for any returned check. 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.

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.

Dr. Dana Michaels is an independent practitioner at IMC. As a patient of Dr. Michaels, 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: _____

The Naturopathic Wellness Center

At Integrative Medical Clinic Of Santa Rosa

Dana Michaels, ND

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. Dana Michaels ◆ 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

Dr. Moses Goldberg ◆ Dr. Dana Michaels ◆ The Naturopathic Wellness Center
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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