



The Naturopathic Wellness Center
At Integrative Medical Clinic of Santa Rosa
Dana Michaels, 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 \$300.00

Follow up visits will average 45-60 minutes and cost \$145.00- \$165.00

Children (12 and under): The initial visit will cost \$225; follow up visits will be \$145.00- \$165.00

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. 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. Dana Michaels is an independent practitioners' 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: _____



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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
Polyyps:	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

<u>FEMALE GENITALIA</u>			
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			

<u>MUSCULOSKELETAL</u>			
Weakness:	Y P	Arthritis:	Y P
Stiffness:	Y P	Leg Cramps:	Y P
Tremors:	Y P	Pain:	Y P
<u>NERVOUS</u>			
Paralysis:	Y P	Sciatica:	Y P
Tingling/numbness:	Y P	Carpal tunnel syndrome:	Y P
Seizures:	Y P	Fainting:	Y P
<u>Mental/Emotional</u>			
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