Naturopathic Wellness Center (NWC)
@ Integrative Medical Clinic (IMC)
175 Concourse Boulevard - Santa Rosa, CA 95403
Phone: 707-284-9200 Fax: 707-284-9204

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 $245.
Follow up visits will average 30 - 45 minutes and cost $105 - $165.
Children (12 and under): The initial visit will cost $225; follow up visits will be $75 - $125.

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.

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 and Dr. Dana Michaels are independent practitioners' at IMC. As a patient of Dr. Goldberg or 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: __________________________________

Comprehensive Patient Health History Questionnaire

Holistic and preventative medicine is best accomplished when the doctor has a thorough understanding of the patient's physical, mental and emotional condition. The information on this questionnaire will help the doctor understand your needs and how to help you reach your health goals.
Please print all information and put a question mark by anything that you don't understand.
Thank you for taking the time and effort to complete this form.

What are your most important health concerns? List as many as you can in order of importance.

1) ____

2) ____

3) ____

When did you last go to the doctor's office, medical clinic or hospital? What was the reason?

____

Childhood immunizations and vaccines

Polio	Yes	No	Diphtheria	Yes	No	Tetanus shot	Yes	No
Pertussis	Yes	No	Measles/Mumps/Rubella	Yes	No			

Other ____

Hospitalizations and/or Surgeries? ____

____

Allergies

Do you have any reaction to foods, drugs or other allergens in your environment (cats, mold, dust)?
Yes _____ No _____ If yes, please explain. ____

____

Current Medications

Please list any prescription medications, over-the-counter drugs, vitamins, minerals, herbs and other supplements that you are taking at this time and how much of these with doses.

1) ______________________ 2) ___________________________ 3) ______________________

Were there any problems during pregnancy or birth (ie drug or alcohol addition, severe stress, premature birth, C-section etc.) ? ____

____

Weight and Height? ____

Review of Symptoms

Check line if any symptoms are current or in the past noteworthy

SKIN & NECK

Rashes ________________ Eczema, Hives ________________
Swollen Glands ________________ Night Sweats ________________

RESPIRATORY

Cough ________________ Spitting up blood ________________
Asthma ________________ Pneumonia ________________
Difficulty breathing ________________ Bronchitis ________________

EYES

Impaired vision ________________ Glasses / Contacts ________________
Plugged Tear duct ________________

CARDIOVASCULAR

High blood pressure ________________ Murmurs ________________

EARS

Impaired hearing ________________ Ringing ________________
Dizziness ________________ Earache ________________

GASTROINTSTINAL

Trouble Swallowing ________________ Reflux ________________
Nausea ________________ Vomiting ________________
Vomiting blood ________________ Burping or gas? ________________
Bowel Movements how often ? ________________ Is this a change? ________________

NOSE and SINUS

Frequent colds ________________ Stuffiness ________________
Hay fever ________________ Sinus problems ________________

MOUTH and THROAT

Frequent sore throat ________________ Gum problems ________________

URINARY

Pain on urination ________________ Frequent infections ________________

FEMALE REPRODUCTIVE

Age menses began ________________ Average number of days ________________
Bleeding between periods ________________ Painful menses ________________

MALE REPRODUCTIVE

Circumcised ? ________________ Descended Testes________________

SLEEP

How long does child sleep in the night? ____________ How often does child wake up? __________________
Does your child nap and for how long? ____________

Does anyone in the household Smoke? ____________
Pets? How Many? __________________________________

New Construction in the home? ___________________ Mold in home? _________________________

Do you read bedtime stories to your child? __________________________________
Does your family eat meals together? __________________________________

Foreign Travel? __________________________________
TV/Computer use – How long? __________________________________