

# BERKELEY NATUROPATHIC MEDICAL GROUP

PATIENT INFORMATION	
Name (last, first, MI) _____	
Address _____	
Preferred Phone # _____	OK to leave detailed messages here? Y N
Alternate Phone # _____	OK to leave detailed messages here? Y N
Email _____	OK to leave detailed messages here? Y N
Gender    M    F    T	Date of Birth _____
Occupation & Employer _____	
Marital Status _____	Name of spouse/partner _____
Names (& Ages) of Children _____	

PRIMARY INSURANCE
Primary Insurance Company Name _____
Type of Insurance (please check all that apply): <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HSA <input type="checkbox"/> FSA <input type="checkbox"/> Other _____
Berkeley Naturopathic Medical Group is a fee for service clinic. Patients are responsible for payment in full at the time of service. Patients will be provided with a super bill that can then be submitted to insurance for possible reimbursement. It is each patients responsibility to inquire about insurance reimbursement and to know the limits of coverage in regards to Naturopathic medicine and Naturopathic Doctors.

EMERGENCY CONTACT INFORMATION	
Emergency Contact _____	Relationship to you _____
Preferred Phone # _____	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Alternate Phone # _____	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Who may we thank for referring you to Berkeley Naturopathic Medical Group?  How did you hear about BNMG?	

# BERKELEY NATUROPATHIC MEDICAL GROUP

## CONTEXT OF CARE

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

- 1.
- 2.
- 3.

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?

(Rate from 0 to 10 with 10 being 100% committed)

1      2      3      4      5      6      7      8      9      10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive? (please list)

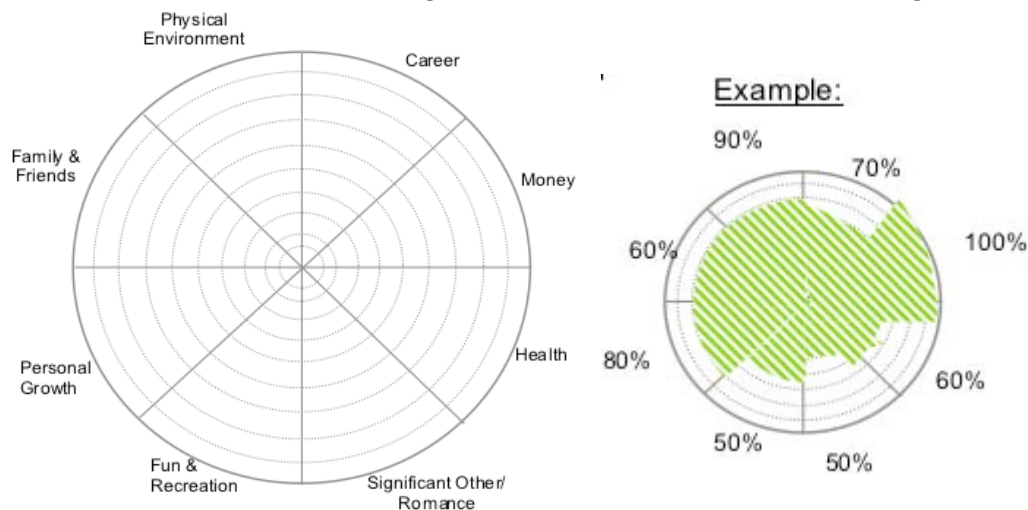
What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

### WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle below, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.



# BERKELEY NATUROPATHIC MEDICAL GROUP

## HEALTH HISTORY QUESTIONNAIRE *For Women*

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

<b>Name:</b> <i>(Last, First, M.I.)</i>		<b>Date</b>	<b>DOB</b>
Primary Care Physician:		Physician Phone #:	
Other healthcare practitioners: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:			
<b>Name:</b>	<b>Type of practice:</b>	<b>Phone number:</b>	
<b>Date of last physical exam:</b>	<b>Date of last pap exam:</b>	<b>Date of last fasting blood labs:</b>	
<b>Please list your current health concerns in order of their importance to you</b>			
<b>Concern:</b>		<b>Date of onset:</b>	
1.			
2.			
3.			
4.			
5.			
<b>Previous medical diagnoses</b>			
<b>Diagnosis:</b>		<b>Diagnosed by:</b>	<b>Date of diagnosis:</b>
1.			
2.			
3.			
4.			
5.			
<b>Traumas, Car Accidents, Injuries:</b>			
<b>Surgeries and Hospitalizations:</b>			
<b>Year</b>	<b>Reason</b>	<b>Hospital</b>	
<b>Have you ever had a blood transfusion?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

CHILDHOOD MEDICAL HISTORY											
<b>Prenatal history:</b>	Any complications during your mother's pregnancy with you? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, describe:										
<b>Birth History:</b>	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Trauma? Any newborn problems? <input type="checkbox"/> Jaundice <input type="checkbox"/> Hospitalization <input type="checkbox"/> Other, describe										
<b>Nourishment</b>	As a baby, were you fed <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Mixed Do you know at what age you first were given solid foods? How would you describe your diet as a child?										
<b>Childhood Illness:</b>	How often did you get sick as a child? What kind of illnesses did you usually experience? i.e. ear infections, sore throat, cough, allergies, asthma...  How often did you take antibiotics? Other medications taken regularly as a child?  Did you ever have: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Pertussis <input type="checkbox"/> Other infectious diseases										
<b>List Any Other Medical Problems You Had As A Child:</b>											
<b>Vaccinations:</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> I am <u>fully</u> vaccinated  <input type="checkbox"/> I am <u>selectively</u> vaccinated  <input type="checkbox"/> I am <u>not</u> vaccinated            Last tetanus booster:            Do you get the flu vaccine?            Ever had an adverse reaction to vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No         </td> <td style="width: 50%; vertical-align: top; border-left: 1px solid black; padding-left: 10px;">           Check those vaccinations you've had:  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> MMR</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> DPT</td> <td><input type="checkbox"/> Pneumonia</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Hepatitis_____</td> <td><input type="checkbox"/> Polio</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> HIB</td> <td><input type="checkbox"/> PPD</td> </tr> </table> </td> </tr> </table>	<input type="checkbox"/> I am <u>fully</u> vaccinated <input type="checkbox"/> I am <u>selectively</u> vaccinated <input type="checkbox"/> I am <u>not</u> vaccinated Last tetanus booster: Do you get the flu vaccine? Ever had an adverse reaction to vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check those vaccinations you've had: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> MMR</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> DPT</td> <td><input type="checkbox"/> Pneumonia</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Hepatitis_____</td> <td><input type="checkbox"/> Polio</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> HIB</td> <td><input type="checkbox"/> PPD</td> </tr> </table>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> MMR	<input type="checkbox"/> DPT	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis_____	<input type="checkbox"/> Polio	<input type="checkbox"/> HIB	<input type="checkbox"/> PPD
<input type="checkbox"/> I am <u>fully</u> vaccinated <input type="checkbox"/> I am <u>selectively</u> vaccinated <input type="checkbox"/> I am <u>not</u> vaccinated Last tetanus booster: Do you get the flu vaccine? Ever had an adverse reaction to vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check those vaccinations you've had: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> MMR</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> DPT</td> <td><input type="checkbox"/> Pneumonia</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> Hepatitis_____</td> <td><input type="checkbox"/> Polio</td> </tr> <tr> <td style="border-right: 1px solid black; padding-right: 5px;"><input type="checkbox"/> HIB</td> <td><input type="checkbox"/> PPD</td> </tr> </table>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> MMR	<input type="checkbox"/> DPT	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis_____	<input type="checkbox"/> Polio	<input type="checkbox"/> HIB	<input type="checkbox"/> PPD		
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> MMR										
<input type="checkbox"/> DPT	<input type="checkbox"/> Pneumonia										
<input type="checkbox"/> Hepatitis_____	<input type="checkbox"/> Polio										
<input type="checkbox"/> HIB	<input type="checkbox"/> PPD										
<b>Home Environment:</b>											
How many children in your family?	Your birth order (3 <sup>rd</sup> of 4 kids...)										
What adults lived with you?											
Was your home safe?											
Did you have any traumas or losses as a child?											
Did you grow up in the city, suburbs or in a rural area?											
Did anyone in your home smoke or use drugs regularly?											

FAMILY HEALTH HISTORY							
<b>Are you adopted?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Family History, note relationship below</b>							
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Allergy		<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Stroke		<input type="checkbox"/> Cancer		<input type="checkbox"/> Substance abuse	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Kidney disease		<input type="checkbox"/> Obesity		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Thyroid disorder		<input type="checkbox"/> Arthritis		<input type="checkbox"/> Autoimmune disease		<input type="checkbox"/> Other	
	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F			
<b>Brothers and Sisters</b>				<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Grandparents (Mother's Side)</b>			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Male</b>			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Female</b>			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Grandparents (Father's Side)</b>			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Male</b>			
<input type="checkbox"/> M <input type="checkbox"/> F				<b>Female</b>			

Please leave this space blank for physician use

<b>MEDICATIONS</b>	
--------------------	--

<b>PRESCRIPTION MEDICATIONS (include strength &amp; frequency taken)</b>	
--	--

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

<b>OVER THE COUNTER DRUGS (include strength &amp; frequency taken)</b>	
--	--

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

<b>SUPPLEMENTS: please list homeopathics, herbs, vitamins &amp; minerals (include strength &amp; frequency taken)</b>	
---	--

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

<b>ALLERGIES</b>	
------------------	--

<b>Name of Drug</b>	<b>Reaction</b>
---------------------	-----------------


<b>Allergies to Foods</b>	<b>Reaction</b>
---------------------------	-----------------


<b>Environmental Allergies</b>	<b>Reaction</b>
--------------------------------	-----------------


ELIMINATION													
<b>GUT:</b>	<p>How often do you have a bowel movement?            Is your stool:  <input type="checkbox"/> Formed <input type="checkbox"/> Loose <input type="checkbox"/> Hard <input type="checkbox"/> Dry <input type="checkbox"/> Greasy  <input type="checkbox"/> Brown <input type="checkbox"/> Tan <input type="checkbox"/> Black <input type="checkbox"/> Green <input type="checkbox"/> Yellow            In your stool, do you ever notice: <input type="checkbox"/> Undigested food <input type="checkbox"/> Bright red blood <input type="checkbox"/> Mucus            Do you strain to pass stool? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasionally            Do you have hemorrhoids? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No            Do you experience gas, bloating or belching daily? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No            Do you ever unintentionally pass stool? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
	<table border="1"> <tr> <td><input type="checkbox"/> Abdominal pain</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td><input type="checkbox"/> Heartburn/ indigestion</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Nausea/ vomiting</td> <td><input type="checkbox"/> Difficulty swallowing</td> </tr> <tr> <td><input type="checkbox"/> Recent change in bowel movements</td> <td><input type="checkbox"/> Hernia</td> </tr> </table>	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn/ indigestion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea/ vomiting	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Recent change in bowel movements	<input type="checkbox"/> Hernia				
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Constipation												
<input type="checkbox"/> Heartburn/ indigestion	<input type="checkbox"/> Diarrhea												
<input type="checkbox"/> Nausea/ vomiting	<input type="checkbox"/> Difficulty swallowing												
<input type="checkbox"/> Recent change in bowel movements	<input type="checkbox"/> Hernia												
<b>KIDNEYS:</b>	<p>How often do you urinate?            Do you have any of the following:  <input type="checkbox"/> Pain with urination <input type="checkbox"/> Must get up at night to urinate  <input type="checkbox"/> Urinate too frequently/ too much <input type="checkbox"/> Leaking urine  <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> when laughing or coughing  <input type="checkbox"/> Urinary flow obstruction <input type="checkbox"/> at other times  <input type="checkbox"/> Dribbling at end of urination <input type="checkbox"/> Kidney stones  <input type="checkbox"/> Recurrent urinary tract infections</p>												
<b>SKIN:</b>	<p>Do you sweat easily? What makes you sweat?            Do you regularly apply lotion or oils to your skin? If so, what type            Do you scrub or dry brush your skin regularly?</p> <p>Note if you have or have had any of the following:</p> <table border="1"> <tr> <td><input type="checkbox"/> Acne</td> <td><input type="checkbox"/> Moles</td> </tr> <tr> <td><input type="checkbox"/> Eczema</td> <td><input type="checkbox"/> Hives</td> </tr> <tr> <td><input type="checkbox"/> Rash</td> <td><input type="checkbox"/> Pigment changes</td> </tr> <tr> <td><input type="checkbox"/> Chronic itching</td> <td><input type="checkbox"/> Skin cancer</td> </tr> <tr> <td><input type="checkbox"/> Dry skin</td> <td><input type="checkbox"/> Hair loss or unusual growth</td> </tr> <tr> <td><input type="checkbox"/> Contact dermatitis</td> <td><input type="checkbox"/> Jaundice- yellowing of the skin</td> </tr> </table>	<input type="checkbox"/> Acne	<input type="checkbox"/> Moles	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Rash	<input type="checkbox"/> Pigment changes	<input type="checkbox"/> Chronic itching	<input type="checkbox"/> Skin cancer	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Hair loss or unusual growth	<input type="checkbox"/> Contact dermatitis	<input type="checkbox"/> Jaundice- yellowing of the skin
<input type="checkbox"/> Acne	<input type="checkbox"/> Moles												
<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives												
<input type="checkbox"/> Rash	<input type="checkbox"/> Pigment changes												
<input type="checkbox"/> Chronic itching	<input type="checkbox"/> Skin cancer												
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Hair loss or unusual growth												
<input type="checkbox"/> Contact dermatitis	<input type="checkbox"/> Jaundice- yellowing of the skin												
<b>LUNGS:</b>	<p>Note if you have had any of the following:</p> <table border="1"> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Can't sleep flat</td> </tr> <tr> <td><input type="checkbox"/> Chronic cough</td> <td><input type="checkbox"/> Painful breathing</td> </tr> <tr> <td><input type="checkbox"/> Difficulty breathing</td> <td><input type="checkbox"/> Recurrent lung infections</td> </tr> </table>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Can't sleep flat	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Painful breathing	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Recurrent lung infections						
<input type="checkbox"/> Asthma	<input type="checkbox"/> Can't sleep flat												
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Painful breathing												
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Recurrent lung infections												
<b>LIVER:</b>	<table border="1"> <tr> <td> <p>Note if you have had any of the following:</p> <input type="checkbox"/> Yellowing of the skin  <input type="checkbox"/> Chronic itching  <input type="checkbox"/> Nausea/ vomiting  <input type="checkbox"/> Abdominal pain  <input type="checkbox"/> PMS  <input type="checkbox"/> Menstrual irregularities</td> <td> <p>Are you unable to tolerate:</p> <input type="checkbox"/> Cigarette smoke  <input type="checkbox"/> Perfume  <input type="checkbox"/> Alcohol  <input type="checkbox"/> Caffeine</td> </tr> </table>	<p>Note if you have had any of the following:</p> <input type="checkbox"/> Yellowing of the skin <input type="checkbox"/> Chronic itching <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> PMS <input type="checkbox"/> Menstrual irregularities	<p>Are you unable to tolerate:</p> <input type="checkbox"/> Cigarette smoke <input type="checkbox"/> Perfume <input type="checkbox"/> Alcohol <input type="checkbox"/> Caffeine										
<p>Note if you have had any of the following:</p> <input type="checkbox"/> Yellowing of the skin <input type="checkbox"/> Chronic itching <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> PMS <input type="checkbox"/> Menstrual irregularities	<p>Are you unable to tolerate:</p> <input type="checkbox"/> Cigarette smoke <input type="checkbox"/> Perfume <input type="checkbox"/> Alcohol <input type="checkbox"/> Caffeine												

OTHER LIFESTYLE FACTORS					
<b>Activity:</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.) <input type="checkbox"/> Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes) After moderate or vigorous exercise, do you feel <input type="checkbox"/> great <input type="checkbox"/> drained				
<b>Weight:</b>	Current weight _____ <input type="checkbox"/> don't know Ideal body weight _____ What is the most _____ and least _____ you have weighed as an adult? (excluding pregnancies) Do you have, or have you ever had, an eating disorder? <input type="checkbox"/> Binging <input type="checkbox"/> Purging <input type="checkbox"/> Avoidance of food Do you diet to lose weight? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take medications, herbs or supplements to lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, list:				
<b>HOME</b>	Is your home a sanctuary for you? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Do you live in an <input type="checkbox"/> apartment <input type="checkbox"/> house <input type="checkbox"/> other Year building was built _____ Who lives with you? <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Name</td> <td style="width: 50%; text-align: center;">Relationship</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table> Do you live with animals? If so, describe _____  Does your home have lead paint? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Is your home moldy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Is your home safe? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Does your home have an alarm system? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have smoke alarms? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Does your home have bars on the windows/door? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a gun in your home? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Relationship		
Name	Relationship				
<b>OCCUPATION</b>	Do you work primarily inside the home? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Do you work outside the home? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what type of work? _____ How many hours a week do you work? _____ How many days a wk? _____ Do you spend most of your day at <input type="checkbox"/> a desk <input type="checkbox"/> computer <input type="checkbox"/> in car <input type="checkbox"/> none Do you take vacations? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Are you happy in your work? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____				

## HABITS

<b>Alcohol:</b>			
Do you drink alcohol? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what kind?			
How many drinks per day? _____ per week? _____			
Are you concerned about the amount you drink? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you considered stopping? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever experienced blackouts? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you prone to "binge" drinking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you drive after drinking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had a problem with drinking in the past?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Tobacco:</b>			
Do you use tobacco currently? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you use tobacco in the past? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you answered yes to either question above, please provide details:			
<input type="checkbox"/> Cigarettes - Pks/day <input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day			
<input type="checkbox"/> Cigars - #/day <input type="checkbox"/> # of Years <input type="checkbox"/> or Year Quit			
<b>Drugs:</b>			
Do you currently use recreational or street drugs? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever given yourself street drugs with a needle? . <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Caffeine:</b>			
Coffee..... <input type="checkbox"/> Yes <input type="checkbox"/> No      Amount:			
Soda..... <input type="checkbox"/> Yes <input type="checkbox"/> No      Amount:			
Caffeinated tea..... <input type="checkbox"/> Yes <input type="checkbox"/> No      Amount:			
Chocolate..... <input type="checkbox"/> Yes <input type="checkbox"/> No      Amount:			
Other..... Amount:			
<b>TOXIC EXPOSURES</b>	<input type="checkbox"/> Pottery	<input type="checkbox"/> Nuclear power plant	<input type="checkbox"/> Asbestos
	<input type="checkbox"/> Glass blowing	<input type="checkbox"/> Frequent air travel	<input type="checkbox"/> Second hand smoke
	<input type="checkbox"/> Painting	<input type="checkbox"/> Electric power lines	<input type="checkbox"/> Other solvents
	<input type="checkbox"/> Model building	<input type="checkbox"/> Mercury fillings	<input type="checkbox"/> Other heavy metals
	<input type="checkbox"/> Cleaning chemicals	<input type="checkbox"/> Other mercury exposure	<input type="checkbox"/> Pesticides
	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Lead paint	<input type="checkbox"/> Pthalates

## SEXUAL AND REPRODUCTIVE HEALTH

**All questions contained in this questionnaire are optional and will be kept strictly confidential.**

**Menstrual History**

At what age did you first bleed? \_\_\_\_\_  
 What was the first day of your most recent period? \_\_\_\_\_  
 How long is your cycle, month to month? \_\_\_\_\_  
 Is your cycle length regular?.....  Yes  No  
 How many days do you bleed? \_\_\_\_\_  
 Is your flow ...  Light  Moderate  Heavy  
 Describe:

PMS? .....  Yes  No  
 Describe:

Do you skip periods? .....  Yes  No  
 Any mid cycle spotting?.....  Yes  No  
 If yes, describe (flow, frequency, etc):

Check if you experience any of the following

**Menstrual Symptoms** (if premenopausal)

- Cramps  
 Swelling  
 Breast tenderness  
 Mood swings  
 Anxiety, Irritability  
 Cravings Describe:  
 Fatigue  
 Confusion  
 Acne  
 None

**Menopausal Symptoms** (if peri/postmenopausal)

- Night sweats  
 Hot flashes  
 Vaginal dryness  
 Fatigue  
 Sleep disturbances  
 Difficulty concentrating  
 Mood swings  
 Anxiety, Irritability  
 Joint pain  
 Weight gain  
 None

**Gynecologic Conditions**

check if you have had any of the following

- |  |   |
|--|---|
| <input type="checkbox"/> Genital herpes      | <input type="checkbox"/> PCOS                     |
| <input type="checkbox"/> Genital warts       | <input type="checkbox"/> Endometriosis            |
| <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Uterine fibroid          |
| <input type="checkbox"/> Chlamydia           | <input type="checkbox"/> Ovarian Cyst             |
| <input type="checkbox"/> Syphilis            | <input type="checkbox"/> Breast lump              |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Fibrocystic breasts      |
| <input type="checkbox"/> HIV                 | <input type="checkbox"/> Nipple discharge         |
| <input type="checkbox"/> PID                 | <input type="checkbox"/> Pain with intercourse    |
| <input type="checkbox"/> Yeast infection     | <input type="checkbox"/> DES exposure             |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Itching, odor, discharge |
| <input type="checkbox"/> Trichomonas         | <input type="checkbox"/> None                     |

**Sexual History**

Are you sexually active?  
 Currently  Past  Never  
 Age you were first consensually sexually active:  
 Partners?  Male  Female  Both  
 Are you in a monogamous relationship?  
 Yes  No  
 Do you have difficulty having an orgasm?  
 Yes  No  
 Feel knowledgeable about safe sex?  
 Yes  No  
 Do you practice safe sex?  Yes  No  
 Any other concerns?  Yes  No  
 Have you ever had an STD screening? If so, when?  
 Have you ever had an abnormal pap?  
 Yes  No  
 Date of last annual gyn exam with pap

**Pregnancy History:**

Date	Outcome (vaginal delivery, caesarean, miscarriage, abortion, etc)	Did you breastfeed?	How long?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you currently trying to get pregnant?.....  Yes  No  
 Have you made any changes in your diet/lifestyle while trying to get pregnant?.....  Yes  No  
 If so, what?

Do you plan to become pregnant in the future?.....  Yes  No  
 If so, when?

Have you ever had difficulty getting or staying pregnant?..... \_Yes\_\_\_No

**Contraceptive History:** *What birth control methods have you used? (Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera...)*

Type:	How long?	Any problems?	Current use?

REVIEW OF SYSTEMS		
<b>Check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.</b>		
<b>CONSTITUTIONAL</b>		
<input type="checkbox"/> Weight	<input type="checkbox"/> Appetite	<input type="checkbox"/> Sense of wellbeing
<input type="checkbox"/> Energy level	<input type="checkbox"/> Strength	<input type="checkbox"/> Libido
<input type="checkbox"/> Sleep	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Other
<b>EYES, EARS, NOSE, MOUTH, THROAT</b>		
<input type="checkbox"/> Vision loss	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Headaches
<input type="checkbox"/> Double vision	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Missing teeth
<input type="checkbox"/> Excessive tearing	<input type="checkbox"/> Vertigo/ dizziness	<input type="checkbox"/> Gingivitis
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Blind spots	<input type="checkbox"/> Chronic stuffy nose	<input type="checkbox"/> Neck stiffness or swelling
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Other
<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Recurrent sinus infections	
<b>HEART AND BLOOD VESSELS</b>		
<input type="checkbox"/> Chest wall pain	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Fainting
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Swelling
<input type="checkbox"/> Short of breath w/mild exercise	<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Leg pain when walking
<input type="checkbox"/> Short of breath lying flat	<input type="checkbox"/> Vessel inflammation	<input type="checkbox"/> Anemia
		<input type="checkbox"/> Other
<b>LUNGS</b>		
<input type="checkbox"/> Painful breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing sputum
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood
	<input type="checkbox"/> Chronic bronchitis	
<b>MUSCULOSKELETAL</b>		
<input type="checkbox"/> Back pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Morning stiffness
<input type="checkbox"/> Bone loss/ fractures	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Hot/red muscles or joints
		<input type="checkbox"/> Limited range of motion
<b>NEUROLOGIC AND PSYCHOLOGICAL</b>		
<input type="checkbox"/> Seizures, convulsions	<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Speech difficulties	<input type="checkbox"/> Suicidal history
<input type="checkbox"/> Numbness/ tingling	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Tremor	<input type="checkbox"/> Depression	
<b>IMMUNE SYSTEM</b>	<b>ENDOCRINE</b>	
How many times a year are you sick? Where do you get sick first? What are your typical 1 <sup>st</sup> symptoms?	<input type="checkbox"/> Breast enlargement-men	<input type="checkbox"/> Spacey feeling after food
Do you recover easily? <input type="checkbox"/> Lymph node swelling	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Waking at night
	<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Fainting
	<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Swelling
	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Leg pain when walking

# BERKELEY NATUROPATHIC MEDICAL GROUP

## Welcome to Berkeley Naturopathic Medical Group!

We are happy that you have chosen to pursue naturopathic medicine at Berkeley Naturopathic Medical Group. Our goal is to provide you with the highest quality naturopathic medical care possible. We are committed to a healthy and honest relationship from the start and for this reason we ask that you take the time to review our appointment and payment policies.

Please sign below to acknowledge that you have read and understand these policies.

### **Fees:**

#### First Office Call:

- General (90-120 min) ..... \$300
- Pediatrics (60 min) ..... \$195
- Acute (30 min) ..... \$105

#### Return Office Call

- 60 min ..... \$195
- 45 min ..... \$150
- 30 min ..... \$105
- 15 min ..... \$55

### **Cancellation Policy:**

At Berkeley Naturopathic Medical Group, we respect your time, and we ask that you please respect ours. We require a minimum of 24 hours notice\* when canceling or rescheduling appointments. (\*For Monday appointments, appointment changes must be received before the close of the office on the Friday before.) If we do not receive a minimum of 24 hours notice, you will incur a credit card charge of 100% of the scheduled office visit cost.

Please understand that this policy is in place as a means of respecting the time and efforts of your physician and her office staff, as well as other patients who would have benefited from a medical visit during this time. Should we have to change appointments, we will do our best to give you 24 hours notice and will be sure to accommodate your needs and re-schedule your appointment in a timely fashion.

### **Phone Consultations:**

Free 10-15 minute initial consultations are available by phone. Included in each office visit fee is one 10 minute phone conversation to answer short questions and clarify treatment instructions. If a call is a substitute for an office visit or results in additional professional advice, prescription or treatment plan change, you will be charged the same as our in-office rates. At the end of the phone call you will be asked to leave a credit card number for billing purposes. Telephone visits are available after an initial in person visit if you are unable to come to our office. These are billed at the regular in-office rate and payment is due via credit card at the end of each call.

### **Email Consultations:**

As with phone consults, we are happy to answer short questions and clarify treatment instructions via email. If the email inquiry results in professional advice, prescription or change in your treatment plan, you will be charged the same as our in-office rate for the time spent answering your questions via email. This charge will be added onto your next in-office visit or billed to you.

### **Supplements:**

All sales on supplements and botanicals are final. Please note that the purpose of selling supplements to patients is to make available the most effective and highest quality products that are often only available for sale through licensed professionals.

It may happen that you need a refill prior to your next appointment. Please call or email with your refill request 5 business days before you are scheduled to finish your supplements. All refills must be paid for at the time they are dispensed and can be picked up at the office or mailed to your home.

**Insurance & Payment:**

Your health insurance policy is a contract between you and your insurance company and you are responsible to know your coverage. Many private insurance companies have policies that do cover some or part of the care you receive from Berkeley Naturopathic Medical Group. Whether your particular policy is one that has such coverage is a detail you can learn from your insurance agent as our office does not have access to that information. All charges incurred at our office are your responsibility regardless of insurance coverage.

Payment in full is due at the time of service. This includes fees for medical office visits, labs and any herbal/nutritional supplements prescribed for you. For your convenience we accept cash, check, Visa, and MasterCard. At the end of each visit, you will be provided with a superbill that you can use to submit to your insurance for possible reimbursement. The Berkeley Naturopathic Medical Group does not bill insurance and currently, federal programs such as Medicare and Medicaid do not reimburse for naturopathic medical services.

*I understand and agree to the conditions listed above.*

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# BERKELEY NATUROPATHIC MEDICAL GROUP

## INFORMED CONSENT FOR TREATMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches are used, including but not limited to, botanical medicine, homeopathy, clinical nutrition, hydrotherapy, physical medicine and lifestyle counseling, all of which are included in the scope of practice for licensed naturopathic doctors in the State of California.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your naturopathic doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your naturopathic doctor immediately.

***I recognize the potential risk and benefits of these procedures as described below:***

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

*Notify Berkeley Naturopathic Medical Group if you experience any symptoms which may be secondary to the above procedures.*

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

**Notice to Pregnant Women:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the doctor, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the day of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential.

I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient Representative or Guardian \_\_\_\_\_