PATIENT INFORMATION

Name (last, first, MI)

Gender M F | Date of Birth

PRIMARY Caregiver(s) & relationship to child

Address____

Preferred Phone # C/W/H OK to leave confidential messages here? Y N

Alternate Phone # C/W/H OK to leave confidential messages here? Y N

Email OK to leave confidential messages here? Y N

SECONDARY Caregiver(s) & relationship to child

Address____

Preferred Phone # OK to leave confidential messages here? Y N

Alternate Phone # OK to leave confidential messages here? Y N

Email OK to leave confidential messages here? Y N

Names (& Ages) of Siblings ____

If divorced parents, describe custody agreement

PRIMARY INSURANCE

Primary Insurance Company Name

Type of Insurance (please check all that apply):

❑ HMO ❑ PPO ❑ HSA ❑ FSA ❑ 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 # ❑ Home ❑ Work ❑ Cell

Alternate Phone # ❑ Home ❑ Work ❑ Cell

How did you find out about the clinic?

If a person, may we thank them for the referral? ❑ Yes ❑ No

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 an health care provider for your child?

What is your present level of commitment to address any underlying causes of your child's signs and symptoms that relate to your child's and family's 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 does your child or family currently engage in regularly that you believe support your child's health? (please list)

HEALTH HISTORY QUESTIONNAIRE *For Children*

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

Form completed by:		**Date:**
Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB**
PRIMARY CARE PEDIATRICIAN:	**Pediatrician Phone #:**	

OTHER HEALTHCARE PRACTITIONERS: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:

Name:	**Type of practice:**	**Phone number:**

Please list your current health concerns for your child in order of their importance to you

Concern:	Date of onset:
1.	
2.	
3.	
4.	
5.	

☐ Yes ☐ No Traumas, Car Accidents, Injuries?

☐ Yes ☐ No Serious Illnesses?

Surgeries and Hospitalizations:

Date	Reason	Hospital

Has your child ever had a blood transfusion? .... ☐ Yes ☐ No

Child's general state of health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical:	**Date of last dental exam (if applicable):**

2615 Ashby Ave | Berkeley, CA 94705 | P: 510.845.8600 | F: 888.972.7331
officemanager@berkeleynaturopathic.com | www.berkeleynaturopathic.com

PRENATAL HISTORY	
Mother's age at child's birth:	Prenatal care? ☐ No ☐ Yes; with whom?:
Difficulty conceiving? ☐ No ☐ Yes; infertility treatments used?	
During pregnancy, did the mother experience:	☐ Bleeding ☐ Drug/Alcohol Abuse ☐ Hypertension ☐ Medications ☐ Physical Trauma ☐ Thyroid Problems ☐ Gestational Diabetes ☐ Other:
During pregnancy, did the mother use any of the following:	☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Prescription Drugs ☐ Over-the-counter medication ☐ Supplements ☐ Other Please give details:

BIRTH HISTORY		
Pregnancy Length: ☐ On time ☐ Premature _______ wks ☐ Late _______ wks		
Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Induced ☐ Forceps ☐Vacuum ☐ Trauma, describe: ☐ Other:		
Length of labor:	**Birth weight:**	**Birth length:**
Any newborn problems? ☐ Jaundice ☐ Rashes ☐ Seizures ☐ Hospitalization ☐ Other, describe		

IMMUNIZATION HISTORY			
☐ Diphtheria: /4	☐ Pertussis: /4	☐ Tetanus: /4	☐ Polio: /4
☐ Hepatitis B: /3	☐ Measles: /2	☐ Mumps: /2	☐ Rubella: /2
☐ H. Flu (HiB): /3	☐ Tetanus booster:	☐ Other:	
Please indicate any adverse reactions to vaccines:			

HEALTH & DEVELOPMENT
How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown
If poor or fair, please describe:
At what age did your child first: ☐ Sit up ☐ Crawl ☐ Walk ☐ Talk
Describe your child's sleep pattern:

FEEDING/DIET HISTORY	
Breast Fed? ☐ No ☐ Yes; how long?	
Formula Fed? ☐ No ☐ Yes; how long? What type?	
What foods were introduced before 6 months and at what approximate age?	
6-12 months?	
Did your child ever experience colic? ☐ No ☐ Yes; how severe? ☐ mild ☐ moderate ☐ severe	
Please list any food allergies or intolerances, along with the reaction they provoke:	
What foods does your child crave/insist upon?	
Does you child have any dietary restrictions (eg, religious, vegetarian/vegan, etc)?	
Describe your child's typical daily diet: BREAKFAST:	SNACKS:
LUNCH:	LIQUIDS:
DINNER:	SWEETS:

PAST MEDICAL HISTORY

Does your child have, or has she/he had:

☐Yes ☐No	Chicken pox	☐Yes ☐No	Constipation requiring a doctor visit
☐Yes ☐No	Ear infections	☐Yes ☐No	Bladder or kidney infection
☐Yes ☐No	Problems with ears or hearing	☐Yes ☐No	Bed-wetting (if over 5 years old)
☐Yes ☐No	Nasal allergies	☐Yes ☐No	(girls) Started menstruating?
☐Yes ☐No	Problems with eyes or vision	☐Yes ☐No	(girls) Any problems with periods?
☐Yes ☐No	Asthma, bronchitis, croup or pneumonia	☐Yes ☐No	Seizures or other neurologic problems
☐Yes ☐No	Heart problems or murmur	☐Yes ☐No	Frequent headaches
☐Yes ☐No	Anemia or bleeding problem	☐Yes ☐No	Chronic or recurrent skin problems
☐Yes ☐No	Frequent abdominal pain	☐Yes ☐No	Diabetes or thyroid problems

Has your child had antibiotics? If so, how many times and for what reasons?

FAMILY HEALTH HISTORY

Is your child adopted? .... ☐ Yes ☐ No

Have any family members had the following? If so, note relationship to child

☐Yes ☐No	Deafness	☐Yes ☐No	Bleeding disorder
☐Yes ☐No	Nasal Allergies/ Hayfever	☐Yes ☐No	Liver disease
☐Yes ☐No	Eczema	☐Yes ☐No	Kidney disease
☐Yes ☐No	Asthma	☐Yes ☐No	Diabetes before age 50
☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bed-wetting after age 10
☐Yes ☐No	Heart Disease before age 50	☐Yes ☐No	Epilepsy or convulsions
☐Yes ☐No	High Blood Pressure before age 50	☐Yes ☐No	Alcohol or drug abuse
☐Yes ☐No	High Cholesterol	☐Yes ☐No	Developmental disability
☐Yes ☐No	Anemia	☐Yes ☐No	Mental illness

SOCIAL HISTORY AND DEVELOPMENT
How would you describe your child's temperament?
Is your child in: ☐ School (grade:) ☐ Daycare ☐ Homecare ☐ Other:
What are your child's favorite activities:
Does your child exercise regularly? ☐ No ☐ Yes; how much, how often?
How much television does your child watch? hrs a ☐ day ☐ week
How often does your child read (not for school): ☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily
How often does someone read to your child: ☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily
Home Environment:
How many children in your home? Child's birth order (3rd of 4 kids…)
What adults live with your child?
Does anyone in the household smoke? ☐ No ☐ Yes, who?
Are there animals in the home? ☐ No ☐ Yes, type:
How is your child's home heated?
Has your child had any traumas or losses?
How would you describe the emotional climate of the child's home?
School Age Children:
☐ Yes ☐ No Has he/she ever been "held back" or had to repeat a grade?
☐ Yes ☐ No Are you concerned about your child's attention span?
☐ Yes ☐ No Does your child like school?
☐ Yes ☐ No Any concerns about your child's behavior in school?
☐ Yes ☐ No Any concerns about how he/she is doing academically?

MEDICATIONS			
INCLUDE **CURRENT** PRESCRIPTION MEDICATIONS, OVER THE COUNDER DRUGS, VITAMINS, HERBS ETC…			
Start date	Name & Brand	Dose/ Strength	Frequency

ALLERGIES	
Name of Drug, environmental or food allergy	Reaction

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 Visit:

- General (90-120 min) ………. $395
- Pediatrics
  1 yr to 17 yrs (90 min)… $325
- Acute (30 -60min) ………. $115- $210

Return Office Visit

- 90 min………………$325
- 60 min …………….. $240
- 45 min …………….... $185
- 30 min …………….. $130
- 15 min …………..… $65

Cancellation Policy:

At Berkeley Naturopathic Medical Group, we respect your time, and we trust that you respect ours. We require a minimum of 2 business days* (not counting Saturdays and Sundays) notice for return patients and 3 business days* notice for new patients when canceling or rescheduling appointments. If we do not receive a minimum of 2-3 business days notice, you will incur a credit card charge of 100% of the scheduled office visit cost. *By 5pm on that business day.

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 2 business days notice and will be sure to accommodate your needs and re-schedule your appointment in a timely fashion.

________ Please initial that you understand and accept this policy

Phone Consultations:

If you are unable to come to our office, follow-up visits via telephone are available after an initial in-person visit. These are billed at the regular in-office rate and payment is due via credit card at the end of each call.

Email Consultations:

Naturopathic treatments are individualized, and often require multiple changes in diet and lifestyle. In between your office visits we are happy to answer short questions that clarify treatment plan instructions via email. However, email is not a substitute for an office visit. Your email questions should be no more that 3-5 lines long and pertain to your current treatment plan. If your doctor determines that your email is too complex, requires an in-depth explanation or professional advice, or will result in an alteration to your treatment plan, please know that your email will be forwarded to our staff. They will contact you to schedule a 15-30 minute phone consult with your doctor so your question may be adequately and appropriately addressed. These calls are billed at the regular in-office rate and payment is due via credit card at the end of each call.

Please be aware that e-mail communication can be intercepted in transmission or misdirected. Please consider communicating any sensitive information by telephone, fax, or mail.

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. Supplement orders requested less than 5 business days in advance will be accommodated as soon as possible but may not be immediate due to available time and stock*. 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. If you need to pick up supplements after hours, supplements are left out at your own risk.

Scent-Free Policy:

Our office is a fragrance-free zone. Please refrain from wearing perfume, cologne, and other scented products when visiting us, in order to support the health of our chemically sensitive clients.

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.
Bounced checks incur a $25 processing fee. Refunds on labs are available with a $25 processing fee, provided the labs were not performed, the kits were not tampered with and are returned in a reusable state and that no more than 10 months have passed since their issue. There are no refunds on services.

I understand and agree to the conditions listed above.

Print Name____

Signature____ Date___________________

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____

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