WELCOME TO BE WELL NATURAL MEDICINE!

236 South Cretin Avenue
Saint Paul MN 55105
(p) 612-440-7710 (f) 866-408-6045

Appointments: What to expect

Initial visits for adults and children ages 13 and up are 75-90 minutes and cost $300. Initial pediatric appointments are 60-75 minutes and cost $250. Payment in full is due at the time of service. Visits include a review of your health history and previous lab results, nutritional assessment, holistic assessment, basic nutritional counseling, and a foundational treatment plan.

Follow up visits are billed at a rate of $180 per hour and typically last 60 minutes, with a minimum charge of 30 minutes. Most patients are advised to have regular follow ups every 4-6 weeks for the first 6-12 months of naturopathic treatment. This allows the time necessary to facilitate deep and holistic healing rather than superficial management of symptoms. During the course of treatment your doctor will monitor your progress, review lab results, and provide more elaborate recommendations and guidance according to your individual needs.

Supplements and other natural medicines will likely be recommended as part of your treatment plan. These costs are in addition to your office visit fee and are tailored to your unique circumstances. If you are working within a budget, please let your doctor know and they will prioritize supplements. Your initial product order will be shipped directly to you. Fullscript, our online dispensary, will be available 24-7 for refilling existing prescriptions.

Laboratory testing may also be recommended on an individualized basis. The lab fees vary and are not included in your visit fee.

Cancellations and rescheduling

Kindly give at least 24 hours' notice. To best serve our patients who are seeking appointments, cancellations with less than 24 hours' notice will be invoiced $75.

Insurance

We are NOT in-network for any health insurance plans and payment in full is due at the end of your appointment. Your Flex Spending or Health Savings Accounts are welcome here! You may submit claims to your insurance on your own; just let us know so we can provide you with the appropriate documentation.

Thanks for choosing Be Well Natural Medicine. We look forward to meeting you!

Elizabeth Orchard ND, Founder
Leslie Vilensky ND
Rachel Alioto ND
Natalia Pellegrino ND

NEW PATIENT CHECKLIST

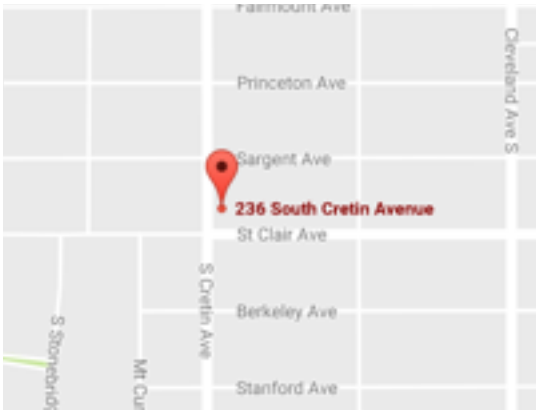
☑ **At least two business days prior to your appointment:**

- ☐ Complete and return your intake form to us via fax, or email it to bewellhelpdesk@gmail.com. **Please do not send photos of the forms.**

☑ **On the day of your appointment:**

- ☐ Bring the original paper copy of the New Patient Intake and copies your labs as a backup in case the fax/email copy did not go through.
- ☐ Bring any medications and supplements that you are currently taking.

☑ **Directions and parking**



We are located on Cretin, half a block north of St. Clair. Look for the black awning and green door. There is a small parking lot at the alley on the north side of our building as well as street parking on St. Clair.

From Interstate 94:
Take Cretin-Vandalia exit 237.
Go south on Cretin about 1.5 miles.
We are on Cretin between Sargent and the light at St. Clair.

From the west on 494:
Go east on 494 to MN-5
Stay on 5 over the bridge
Exit on Edgecumbe Road
Turn L onto St Paul Avenue
Continue onto Cleveland Avenue
Turn L onto Randolph.
Turn R onto Cretin.

From the north on 35E:
Take Victoria Street exit 104C
Go L on Victoria Street South
Go R on West Jefferson Avenue
Go R onto the Ayd Mill Road ramp
Go L on St. Clair
Go R on Cretin

From the south on 35E:
Take Ayd Mill Road exit 104B
Go L on St. Clair
Go R on Cretin

Adult Intake Form

Ages 13 and up

Be Well Natural Medicine, LLC

236 South Cretin Avenue, St. Paul MN 55105

(p) 612-440-7710 (f) 866-408-6045

bewellhelpdesk@gmail.com

Name _____Today's Date _____ / _____/ _____ Birth date _____/_____/ _____

Address_____City/State/Zip_____

Email_____ Preferred Phone _____

Gender: Female____ Male____ Married ____Separated____ Divorced____ Widowed____ Single____ Partnership____

Live with: Spouse____ Partner____ Parents____ Children____ Friends____ Alone ____

Occupation:_____ Hours per week:_____ Employer:_____

Hobbies/Interests:_____

How did you find Be Well Clinic? Please check one:

☐ Referred by _____

☐ Minnesota Association of Naturopathic Physicians website ☐ American Association of Naturopathic Physicians website

Wheel of Balance

Wellness is a balance of many factors. Using the circle, 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.

Are you currently receiving healthcare? Y / N: If yes, where and from whom:_____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

Do you have any known contagious diseases at this time? Y N: If yes, what?_____

List current and ongoing health concerns:	Rate: Mild/Moderate/Severe	Date of Onset
1)		
2)		
3)		
4)		
5)		

What goal(s) do you have for today's appointment?_____

What is your present level of commitment to making healthy lifestyle choices? (Rate from 0 to 10 with 10 being 100% committed):

1 2 3 4 5 6 7 8 9 10

Family History

Do you have a family history of any of the following (please check)?

_____Cancer _____Diabetes _____Heart Disease _____High Blood Pressure _____ Osteoporosis _____Anemia

_____Kidney Disease _____Epilepsy _____Arthritis _____Glaucoma _____Tuberculosis _____Stroke

_____Mental Illness _____ Alcoholism _____Asthma/Hayfever/Hives _____ Endometriosis

_____Alzheimer's or Dementia _____Ulcers _____Celiac Disease _____Migraines _____ Thyroid Disorder

_____ Autism/Asperger's _____ADD/ADHD Other_____

Childhood Illnesses

Please check whether you had any of these as a child:

_____Scarlet fever _____Diphtheria _____Rheumatic fever _____Measles/Mumps/German measles _____Chicken Pox

_____Frequent colds/flus _____Frequent fevers _____Tonsillitis _____Ear infections _____Allergies/Hives _____Eczema/

Skin Condition _____Asthma _____Exposure to second hand smoke _____Urinary Tract Infections

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, or imaging studies (i.e. x-rays, CT Scans, MRIs, EEGs, EKG's) have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental substances or chemicals? _____

Current Medications

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

(You may attach a separate list if extra space is needed.)

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

How often have you taken antibiotics?	Less than 5 times	Greater than 5 times
Infancy/Childhood		
Teens		
Adulthood		

General

Height:_____ Weight: lbs. _____ Weight 1 year ago: lbs. _____

Maximum Weight : _____When: _____

When during the day is your energy the best?_____ worst? _____

Food Intake for the last 3 days

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Habits

Do you exercise? Y N If yes, what kind? How often? _____

Do you use tobacco?	Y N P	Do you drink cola/other sodas?	Y N P
Smoked previously?	Y N P	Drink coffee?	Y N P
How many years? ____ How many packs per day? ____		Drink black/green tea?	Y N P
Use recreational drugs?	Y N P	Do you add salt?	Y N P
Type and frequency_____		Do you eat refined sugar?	Y N P
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
How many drinks per week?_____		Do you go on diets often?	Y N
Treated for alcoholism or drug dependence?	Y N P	Do you eat out often?	Y N
Do you have a history of abuse?	Y N P	Average 6-8 hours sleep every night?	Y N
Any major traumas?	Y N P	Awaken rested?	Y N
Do you have a religious or spiritual practice?	Y N P		

If yes, what? _____

Mental / Emotional

Treated for emotional concerns?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Restlessness/Irritability?	Y N P
Reduced sex drive?	Y N P	Easily stressed?	Y N P

Immune

Reactions to immunizations/vaccines?	Y N P	Allergies?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Autoimmune disease?	Y N P	Lyme Disease?	Y N P
Mononucleosis?	Y N P	Were you breast fed as an infant?	Y N

Endocrine

Hypothyroid or hyperthyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
Headaches or migraines?	Y N P	Learning disabilities?	Y N P
Poor physical coordination?	Y N P	Difficulty making decisions?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

Eyes

Spots in eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P
Itchy, swollen, red or sticky lids?	Y N P	Bags or dark circles under eyes?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches or ear infections?	Y N P	Dizziness?	Y N P
Itchy ears?	Y N P	Fluid or discharge from ear?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hayfever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore or swollen tongue/lips?	Y N P
Swollen or bleeding gums?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Gagging/frequent need to clear throat?	Y N P
Canker sores?	Y N P		

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina or chest pain?	Y N P
High/Low Blood Pressure?	Y N P	Irregular or skipped heartbeats?	Y N P
Rapid or pounding heartbeat?	Y N P	Blood clots?	Y N P
Fainting?	Y N P	Phlebitis?	Y N P
Rheumatic Fever?	Y N P	Swelling in ankles?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching, bloating, or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a change? _____	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P
Lactose intolerance?	Y N P	Parasites?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Feeling of weakness or tiredness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Osteoporosis?	Y N P		

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Men Only

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control?	Y N P	Syphilis?	Y N P
Type?_____			

Women Only

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms? _____		What type? _____	
Number of pregnancies: _____		Number of abortions: _____	
Number of live births: _____		Number of miscarriages: _____	
Ovarian cysts?	Y N P	Endometriosis?	Y N P
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Condyloma?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Environmental Exposures

Do you use plastic containers to store food or drinking water?	Y N P
Do you eat microwaved foods that come packaged with plastic wrap?	Y N P
Do you eat nonorganic cereals, bread, or other grain products?	Y N P
Do you use cosmetics, perfumes, or hair colorings regularly?	Y N P
Do you live or work in an area that has synthetic carpeting?	Y N P
Do you live or work near agricultural areas?	Y N P
Do you live or work in an area that has painted walls or ceilings?	Y N P
Do you use sugar substitutes or eat any low-calorie sugar substitutes or sweeteners?	Y N P
Do you eat foods that contain hydrogenated fats, such as margarine?	Y N P
Do you eat fat-free foods or snacks made with fat substitutes?	Y N P
Do you eat nonorganic fruits, vegetables, grains, meats, or dairy?	Y N P
Do you have your clothes dry-cleaned?	Y N P
Do you routinely have your home and/or yard sprayed with pesticides or do you spend time in areas that do (i.e. golf course)?	Y N P
Have you received 3 or more vaccinations?	Y N
Do you have metal fillings in your teeth?	Y N P
Have you had surgery that used anesthesia?	Y N
Do you use Teflon, non-stick, or aluminum cookware?	Y N P

Please fax or email your completed form to our office prior to your appointment.

Bring the original copy along with you, as well as any medications and supplements you currently take. We look forward to meeting you!