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 with Dr. Orchard for adults and children ages 13 and up are 75-90 minutes and cost $375. Initial pediatric appointments are 60-75 minutes and cost $300. 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 $225 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!

Dr. Elizabeth Orchard ND, Founder

NEW PATIENT CHECKLIST

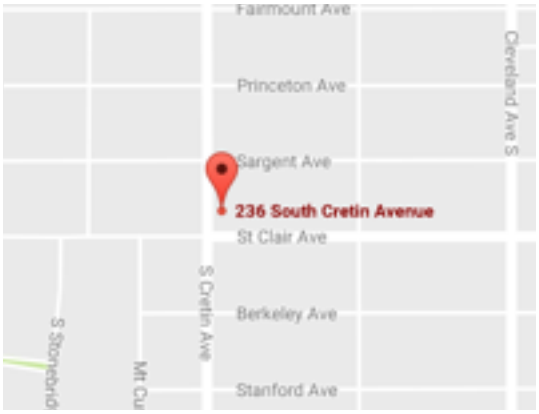
☑ **At least two business days prior to your appointment:**

- ☐ 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

Pediatric Intake Form

Ages 12 and under

Be Well Natural Medicine, LLC
236 South Cretin Avenue, St. Paul MN 55105
(p) 612-440-7710 (f) 866-408-6045
bewellhelpdesk@gmail.com

Child/Patient's Name_____ Date:_____
Age: _____ Date of Birth: _____ Sex & Gender: _____
Parent/Guardian's Name: _____ Occupation: _____
Parent/Guardian's Name: _____ Occupation: _____
Address:_____
City: _____ State: _____ Zip: _____
Telephone (home): _____ (Parent's work): _____
Parent's email address: _____

Name, address, phone of your child's pediatrician:
_____
_____

How did you hear about Be Well Natural Medicine?
_____

Reason for today's visit/main concerns:
_____
_____
_____
_____

MEDICATIONS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Ibuprofen
____	____	Asthma medications/Inhalers	____	____	Other _____
____	____	Other _____	____	____	Other _____

Does your child have any allergies to medications, foods, or other allergens in your environment (cats, mold, dust)? Yes No
If yes, please list and explain:
_____
_____
_____

MEDICAL HISTORY

Check those that apply

____ Chicken pox	____ Scarlet fever	____ Tonsillitis, approx no. of times: _____
____ Measles	____ Pneumonia	____ Ear infections, approx no. of times: _____
____ Mumps	____ Frequent colds	____ Strep throat, approx no. of times: _____
____ Rubella	____ Rheumatic fever	____ Eczema

____ Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS
Electroencephalogram (EEG):

_____

Psychological evaluations:

_____

Hearing test:

_____

Speech/language tests:

_____

Injuries/surgeries/hospitalizations (please list with dates):

_____

_____

_____

IMMUNIZATIONS

Please write approximate date or age when given on line next to immunizations received:

_____ MMR _____ DPT _____ Chicken pox
_____ Measles _____ Diphtheria _____ Small pox
_____ Mumps _____ Tetanus _____ H. influenza
_____ Rubella _____ Polio _____ H1N1 flu
Hepatitis B _____1st _____2nd _____3rd
Others: _____
Did your child have any adverse reactions to immunizations? (Please specify)

_____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis ____ Other significant:_____

PRENATAL HISTORY

Previous pregnancies by birth mother, miscarriages, or complications?

_____

_____

_____

Mother's age at child's birth: _____
Mother's health during pregnancy:
____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Medications ____ Diabetes ____ Thyroid problems
Other: _____

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late
Weight at birth: _____
Length of labor: _____
Complications of Labor/Delivery: _____

Complications Post Partum: _____
Medications given: _____
Did your child have any of the following problems shortly after birth?
____ Rashes ____ Birth injuries ____ Blue baby
____ Jaundice ____ Seizures ____ Cerebral palsy
____ Colic ____ Fever ____ Birth defects
____ Other: _____
Child's sleep patterns (1st year):
_____
_____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy):_____
Age began solids: _____ Which foods:_____
Age began: Sitting _____Crawling _____Walking _____Talking _____First tooth _____

SYMPTOMS

Circle the response that applies
Y: condition now
P: condition had in the past
N: condition never had

Hives	Y	P	N	Burning of urine	Y	P	N
Eczema	Y	P	N	Bloody urine	Y	P	N
Acne	Y	P	N	Frequent urination	Y	P	N
Chronic rash	Y	P	N	Heart murmur	Y	P	N
Cries easily	Y	P	N	Vomiting spells	Y	P	N
Bleeding gums	Y	P	N	Night sweats	Y	P	N
Nervous	Y	P	N	High fever	Y	P	N
Nose bleeds	Y	P	N	Stomach aches	Y	P	N
Sleep problems	Y	P	N	Diarrhea	Y	P	N
Nightmares	Y	P	N	Constipation	Y	P	N
Dizzy spells	Y	P	N	No appetite	Y	P	N
Unusual fevers	Y	P	N	Motion/car sick	Y	P	N
Anemia	Y	P	N	Sensitive to light	Y	P	N
Jaundice	Y	P	N	Body/Breath odor	Y	P	N
Hearing loss	Y	P	N	Easy bruising	Y	P	N
Flat feet	Y	P	N	Sore throats	Y	P	N
Gas	Y	P	N	Canker sores	Y	P	N
Wheezing	Y	P	N	Cough	Y	P	N
Joint Pains	Y	P	N	Hair loss	Y	P	N
Frequent headaches	Y	P	N	Frequent colds	Y	P	N
Bleeding tendency	Y	P	N	Excessive fatigue	Y	P	N

Does your child have any other conditions not mentioned?
_____
_____
_____

DIET

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: _____

Does your child have any food intolerances or allergies that you know of? Yes No
If yes, please explain: _____
_____

What were the first solid foods introduced into your child's diet?
_____

Are there any religious or cultural beliefs or practices of which you would like us to be aware?
_____

Please fax or email your completed form to our office **at least 2 business days prior to your appointment**.

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