Appointments: What to expect
Initial visits for adults and children ages 13 and up are 75-90 minutes. Initial pediatric appointments are 60-75 minutes. Visits include a review of your health history and previous lab results, nutritional assessment, holistic assessment, basic nutritional counseling, and a foundational treatment plan. Payment in full is due at the time of service. Our fee schedule is posted at bewellnaturalmedicine.com/policies.

Follow up visits are billed at a flat rate by 3 duration intervals: Standard (up to 60 min), Extended (up to 90 min) or, by provider preapproval, Abbreviated (<30 min). Most patients are advised to have Standard 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
Dr. Leslie Vilensky, ND
Dr. 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 (833-817-5943), 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.

☐ Location and parking

![Map of location]

We are co-located with GrandHealth Chiropractic & Wellness, located just south of Interstate 94 at 1025 Selby Ave Suite 101, St. Paul MN 55104. We’re on the north side of the street, 2 blocks east of Lexington Parkway in the same building as Statera Fitness. There is ample parking in lot in front of the building, as well as on-street parking on Selby.
Pediatric Intake Form
Ages 12 and under

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

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<th>NOW</th>
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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

<table>
<thead>
<tr>
<th></th>
<th>Chicken pox</th>
<th>Scarlet fever</th>
<th>Tonsillitis, approx no. of times:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Measles</td>
<td>Pneumonia</td>
<td>Ear infections, approx no. of times:</td>
</tr>
<tr>
<td></td>
<td>Mumps</td>
<td>Frequent colds</td>
<td>Strep throat, approx no. of times:</td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td>Rheumatic fever</td>
<td>Eczema</td>
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<tr>
<td></td>
<td>Other:</td>
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</tbody>
</table>
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: _________________________________________

Page 4 of 6
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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y</th>
<th>P</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hives</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Eczema</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Acne</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Chronic rash</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Cries easily</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Bleeding gums</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Nervous</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Sleep problems</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Y</td>
<td>P</td>
<td>N</td>
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<tr>
<td>Dizzy spells</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Unusual fevers</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Anemia</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Jaundice</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Flat feet</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Gas</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Joint Pains</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Frequent headaches</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>Bleeding tendency</td>
<td>Y</td>
<td>P</td>
<td>N</td>
</tr>
</tbody>
</table>

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!