Three Sisters NATURAL HEALTH

Bonnie Skakel, N.D., L.Ac.
Naturopathic Doctor and Acupuncturist

Pediatric Intake Packet (6 to 12 years)

Welcome to Three Sisters Natural Health, LLC. In order to provide your child with the best possible care, we ask you to complete this form in its entirety. Thank you.

Personal Information

Child's Name: _____ Date: _____
Prefers to be called: _____
Age: _____ Date of birth: _____ Gender: F / M Ethnic heritage: _____
Parent(s)/legal guardian(s) names & relationship: _____
Address:_____
Telephone: (home): _____ (Parent's work): _____(cell): _____
Second parent/guardian living at different address:
Name(s) and relationship _____
Sibling names and ages: _____

Preferred phone number for messages/appointment reminders?_____
May Three Sisters Natural Health identify themselves when leaving a message? Y / N
Is it okay to leave a message with detailed information? Y / N
Parent's e-mail: _____

How did you hear about our clinic?_____ May we thank them for the referral? Y / N
Has any other family member been seen at Three Sisters Natural Health? _____

Pediatrician Information:

Name: _____ Phone: _____ Clinic Name _____

Emergency Contact

Name: _____
Relationship to Child: _____
Address: _____
Home #: _____ Work #: _____

Insurance Information

Primary Insurance Company: _____ Phone # : _____
Policy Holder's Name: _____ DOB: _____
Type of Insurance: GRP PRIV WC MVA
Policy ID Number: _____ Group # : _____
Coverage:
Acupuncture: Y N _____
Chiropractic: Y N _____
Massage: Y N _____
Naturopathic: Y N _____
Deductible: _____ Met: _____
# of Visits: _____ Met: _____
Additional Information: _____

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Current Health History

Your main goal for this appointment: _____

What are your child's **most important health concerns**?

1)_____
2)_____
3)_____

Treatments he/she has received for this/these conditions (please circle):
Acupuncture Chiropractic Cranio-Sacral Homeopathy MD Massage Naturopathic Osteopathy Shiatsu

Are there others in your family with the same condition? _____

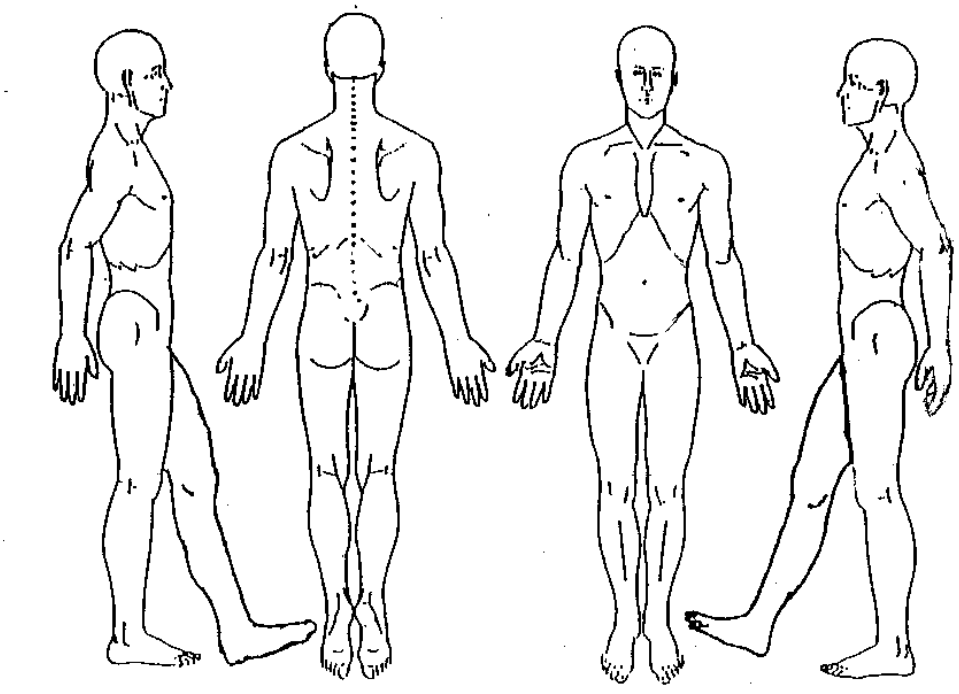
To what extent does this problem interfere with his/her daily activities? (sleep, play, school, meals, etc.):
_____

Medications he/she now takes: _____

Herbs, home remedies, vitamins: _____

Does your child have any known contagious diseases at this time? Y / N
If yes, what?_____

PLEASE INDICATE AREAS OF HIS/HER DISCOMFORT/ PAIN



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Health History

Was your child breastfed? Y / N For how long? _____
Has your child been exposed to second hand smoke? Y / N For how long? _____

Medication/Supplement History: (Y = currently taking, N = never taken, P = past use)

aspirin	Y N P	antibiotics	Y N P	decongestant	Y N P
Tylenol	Y N P	anti-histamine	Y N P	inhalers	Y N P
ibuprophen	Y N P	asthma meds	Y N P	topical steroids	Y N P
Other:			Allergies to medications:		
Vitamins or Supplements currently taking (indicate dosages):					

Imaging and Special Studies:

CT scan	Y N	hearing	Y N	Reading/writing	Y N
ECG/EKG	Y N	MRI	Y N	Speech/language	Y N
EEG	Y N	Psychological eval.	Y N	x-ray	Y N
Other(s):					
If any of the above are circled Yes, please note reason/year of study:					

Injuries/Surgeries/Hospitalizations:

1. _____
2. _____
3. _____

Immunizations:

diphtheria	Y N	measles	Y N	polio	Y N
DPT	Y N	MMR	Y N	small pox	Y N
influenza	Y N	mumps	Y N	tetanus	Y N
Any adverse reactions to immunizations? Y / N (Please describe):					

Childhood Diseases/Illnesses:

___bronchitis	___measles	___rheumatic fever	___frequent colds, # of times:___
___chicken pox	___mumps	___rubella	___ear infections, # of times:___
___croup	___pneumonia	___scarlet fever	___strep throat, # of times:___
Other(s):			

Allergies

Is your child hypersensitive or allergic to….
Any drugs?_____
Any foods?_____
Environmental allergens/chemicals?_____

Diet

Does your child follow a specific diet? Please explain:_____
Typical Food Intake:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Beverages:_____

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Habits

___TV # hours/day:	spends time outside daily Y N	Drinks soda Y N
___Reads # hours/day:	Eats refined sugar Y N	

Please circle: Y = a condition your child has now, N = never had, P = has had in the past:

Head

Headaches	Y	N	P
Head injury	Y	N	P
Migraines	Y	N	P
Jaw/TMJ problems	Y	N	P

Eyes

Impaired vision	Y	N	P
Blurriness	Y	N	P
Color blindness	Y	N	P
Glasses/contacts	Y	N	P
Eye pain/ strain	Y	N	P
Tearing, dryness	Y	N	P

Ears

Impaired hearing	Y	N	P
earaches	Y	N	P
Ringing	Y	N	P
Ear infections	Y	N	P
	Y	N	P
	Y	N	P

Nose and Sinuses

Frequent colds	Y	N	P
Sinus problems	Y	N	P
stuffiness	Y	N	P
Nose bleeds	Y	N	P
Hay fever	Y	N	P
Loss of smell	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P
Hoarseness	Y	N	P
Teeth grinding	Y	N	P
Dental cavities	Y	N	P
Breath odor	Y	N	P
Canker sores	Y	N	P

Neck

Lumps in neck	Y	N	P
Difficulty swallowing	Y	N	P
Neck pain, stiffness	Y	N	P
	Y	N	P
	Y	N	P
	Y	N	P

Respiratory

Cough	Y	N	P
Asthma	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Sputum	Y	N	P
Wheezing	Y	N	P
Shortness of breath	Y	N	P

Cardiovascular

Heart disease	Y	N	P
Heart murmurs	Y	N	P
Congenital defect	Y	N	P

Gastrointestinal

Change in appetite	Y	N	P
Vomiting	Y	N	P
Constipation	Y	N	P
Blood in stool	Y	N	P
Heartburn	Y	N	P
Nausea	Y	N	P
Stomach aches	Y	N	P
Diarrhea	Y	N	P
Motion/car sickness	Y	N	P

bowel movements/day: _____

Urinary

Urinary frequency	Y	N	P
unusual color/odor	Y	N	P
Urinary tract infections	Y	N	P
Bedwetting	Y	N	P
Frequency at night	Y	N	P
Kidney disease	Y	N	P

Male Reproductive

Hernias	Y	N	P
Testicular pain	Y	N	P
Testicular masses	Y	N	P
Undescended testicle	Y	N	P

Female Reproductive

Age of first menses: _____
Length of cycle: _____
Duration of menses _____ days

Are cycles regular	Y	N	P
Clotting	Y	N	P
Cramping	Y	N	P
Bleeding between cycles	Y	N	P
Heavy flow	Y	N	P
Nipple discharge	Y	N	P
Vaginal pain	Y	N	P
Vaginal itching	Y	N	P
Vaginal discharge	Y	N	P
Breast tenderness	Y	N	P
Breast lump	Y	N	P

Immune

Chronic swollen glands	Y	N	P
High fevers	Y	N	P
Slow wound healing	Y	N	P
Night sweats	Y	N	P

Endocrine

Heat/cold intolerance	Y	N	P
Diabetes	Y	N	P
Low blood sugar	Y	N	P
Excessive hunger	Y	N	P
Excessive thirst	Y	N	P
fatigue	Y	N	P

Musculoskeletal

Joint pain, stiffness	Y	N	P
Broken bones	Y	N	P
Muscle spasms, cramps	Y	N	P
Flat feet	Y	N	P

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Skin		**Neurological**		**Blood/ Peripheral Vascular**	
rashes	Y N P	Seizures	Y N P	Easy bleeding	Y N P
Acne, boils	Y N P	Muscle weakness	Y N P	Easy bruising	Y N P
Color changes	Y N P	Vertigo, dizziness	Y N P	anemia	Y N P
Dry skin	Y N P				
Eczema	Y N P				
Itching	Y N P				
Hives	Y N P				
		Mental/ Emotional			
Treated for emotional problems	Y N P	Poor concentration	Y N P	Unusual fears	Y N P
Anxiety, nervousness	Y N P	Hyperactivity	Y N P	Eating disorder	Y N P
irritability	Y N P	Sleep problems	Y N P	nightmares	Y N P
depression	Y N P	Mood swings	Y N P	Cries easily	Y N P

Family Medical History:

Was your child adopted?	Y N	**If yes, please inform physician directly.**

General Family Medical History (if known):
(please specify M=mother, F=father, S=sister, B=brother, A=aunt, U=uncle, PGM=paternal grandmother, PGF=paternal grandfather, MGM=maternal grandmother, MGF=maternal grandfather):

___arthritis	___diabetes	___heart disease
___allergies	___eczema	___mental illness
___cancer	___hay fever	___high blood pressure
___other:		

Mother's Prenatal History (if known):

Prior pregnancies, miscarriages: _____
Mother's age at child's birth: _____ Was the birth: vaginal___ or by C-section___
Mother's health during pregnancy:

___bleeding	___hypertension	___cigarettes, alcohol, drugs
___nausea	___diabetes	___physical or emotional trauma
___illness	___thyroid problems	___stress
___other:		

A Few Final Questions:

1. Any information about your child's health that you would like to add?_____
2. On a scale of 1-10, how committed are you to working with your child to improve his or her state of health? _____
3. On a scale of 1-10, how much change are you willing to make at this time for improving your child's state of health? _____

Thank you. I look forward to meeting your goals for this visit and to helping your child in every way I can.
If you have any questions please ask!
~ Dr. Bonnie Skakel

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Informed Consent and Request for Naturopathic Medical Care, Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Bonnie Skakel, ND, L.Ac, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I,_____, hereby request and consent to examination and treatment with Naturopathic Medicine and Chinese Medicine by Dr. Bonnie Skakel, ND, L.Ac, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Bonnie Skakel, ND, L.Ac, and/or with the allied health care provider providing backup:

1.) my suspected diagnosis(es) or condition(s)
2.) the nature, purpose, goals and potential benefits of the proposed care
3.) the inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) the probability or likelihood of success
5.) reasonable available alternatives to the proposed treatment procedure
6.) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and therapeutic adjustment (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic adjustment of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

The scope of practice of acupuncture is outlined below. I understand that Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)

- Herbs (use of patented herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Bonnie Skakel, ND, L.Ac,, of these conditions. Please Initial:

____I understand that Dr. Bonnie Skakel, ND, L.Ac, is not licensed to prescribe any controlled substances.

____I understand that Dr. Bonnie Skakel, ND, L.Ac will provide the appropriate referrals to manage any prescription medicine needs.

____I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

____I understand that Dr. Bonnie Skakel, ND, L.Ac is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Bonnie Skakel, ND, L.Ac, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Skakel explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient_____ Signature of Patient_____

Printed Name of Guardian_____ Signature of Guardian_____

Date Signed_____

Please fill out both sides of this page.

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Notice of Privacy Practices
Three Sisters Natural Health, LLC

Three Sisters Natural Health, LLC refers to Dr. Bonnie Skakel, her student preceptors and her contracted employees.

This notice describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully. We are legally obligated to provide this information to you. It is subject to change and updated versions are always available from Dr. Skakel.

Three Sisters Natural Health, LLC is the private medical practice of Dr. Bonnie Skakel. The majority of the time Dr. Skakel is the only person with access to your medical information; however, there are a few instances in which she may share pertinent information about you for the purposes of treatment, payment or health care operations. She may disclose your health information to other health professionals, their staff or students who may consult on your treatment or the coordination of your health care.

Three Sisters Natural Health, LLC also uses and discloses your health information for billing and payment collection from you, an insurance company, or someone else for health care services you receive from us. We may also tell your insurance company about your proposed treatment to determine whether your plan will pay for the treatment.

We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance, and business functions of Three Sisters Natural Health, LLC. Data about effectiveness of treatments and what services we should offer may be gathered from patient's health information. We may also use and disclose your health information to contact you regarding treatment options, products or services and for appointment reminders.

Other potential instances in which your health information could be disclosed without your explicit permission include legal obligations at the federal, state or local level to disclose to specified parties for purposes including subpoenas/ court orders, public health risks, governmental agency oversight of health care, threats to health or safety, disaster relief, national security, for identification of deceased persons, or for the purpose of organ or tissue transplantation. Military command or government authority may acquire information about veterans or members of the military. Correctional institutions may acquire information about inmates for the purpose of providing health care and safety. Information about employees can be disclosed to employers regarding worker's compensation type programs.

With some rare exceptions, you have the right to access and get a copy of any data regarding your health information from Three Sisters Natural Health, LLC. In the exceptional cases in which we are permitted to withhold information from you, you may ask that the denial be reviewed. You have the right to amend your health information. We will amend the information, except if it a) is not information that we created, (unless the source of the information is no longer available to make the amendment), b) is not part of the health information that we keep c) is of a type that you would not be permitted to inspect and copy; d) is already accurate and complete.

Dr. Skakel and all associates of Three Sisters Natural Health, LLC seek to maintain confidentiality regarding your health information. We are happy to discuss your concerns about these matters and consider further restricting use and disclosure of your health information.

Signature_____ Date Signed_____

Printed Name Relationship to Patient_____

Please fill out both sides of this page.