Three Sisters NATURAL HEALTH

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

Adult Intake Packet

Welcome to Three Sisters Natural Health. In order to provide you with the best possible care, we ask you to complete this form in its entirety. If possible, mail, fax, email, or drop this form off at the clinic prior to your appointment so that Dr. Skakel can review your health history ahead of time. Otherwise, just bring it with you to the appointment. Thank you.

Personal Information

Name ____ Date ___________________________
Address ____
City _________________________________ State _______________ Zip code ____________________
Phone (hm) ____________________ (wk) ______________________ (cell) ________________________
May we leave messages and appointment reminders? Yes________ No ________
E-mail _____________________________________ Social Security # ____________________________
Age _____ **Date of birth** ___________ Birth Gender: F M NG Identified Gender: F M NG

☐Married ☐Partnership ☐Single ☐Separated ☐Divorced ☐Widowed

Live with: ☐Spouse or partner ☐Parents ☐Children ☐Friends ☐Alone

Occupation ____________________ Hours per week ________ Retired _______ Years __________
Employer ____
What is your ethnic heritage and/or cultural upbringing?_______________________________________
Have you seen a Naturopathic Physician or Acupuncturist before? Yes_____ No______
Which one?____
How did you hear about this clinic?____
May we thank them for the referral? Yes________ No ________
Has any other family member been a patient at the clinic?_____________________________________

Emergency Contact

Name: ____
Address: ____
Home #: _______________________ Work #: ______________________

Insurance Information

Primary Insurance Company: _______________________________ Phone # : ______________________
Policy Holder's Name: ____ DOB: ______________
Type of Insurance: GRP PRIV WC MVA
Policy ID #: ___________________________________ Group # : _______________________________
Coverage:
Acupuncture: Y N ____________________________
Chiropractic: Y N ____________________________
Massage: Y N ____________________________
Naturopathic: Y N ____________________________
Deductible: ________________ Met: ______________
# of Visits: ________________ Met: ______________
Additional Information: __________________________

CONTEXT OF CARE

Successful health care and preventive medicine are possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will help me understand your needs and how to help you reach your health goals. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic?

What do you know about our approach?

2) What three expectations do you have from ***this*** visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6) Who do you know who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Current Health History

Do you have a Primary Care Provider? Y / N

If yes, may we have their name, location, and phone number: ____
____

What are your **most important health concerns**?

1)____

2)____

3)____

Treatments you have received for this/these conditions (please circle):
Acupuncture Chiropractic Cranio-Sacral Homeopathy MD Massage Naturopathic Osteopathy

Have you had recent lab work and/or imaging done? (We may ask to see copies of the results.)

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

To what extent does this problem interfere with your daily activities? (sleep, play, work, meals, etc.):
____

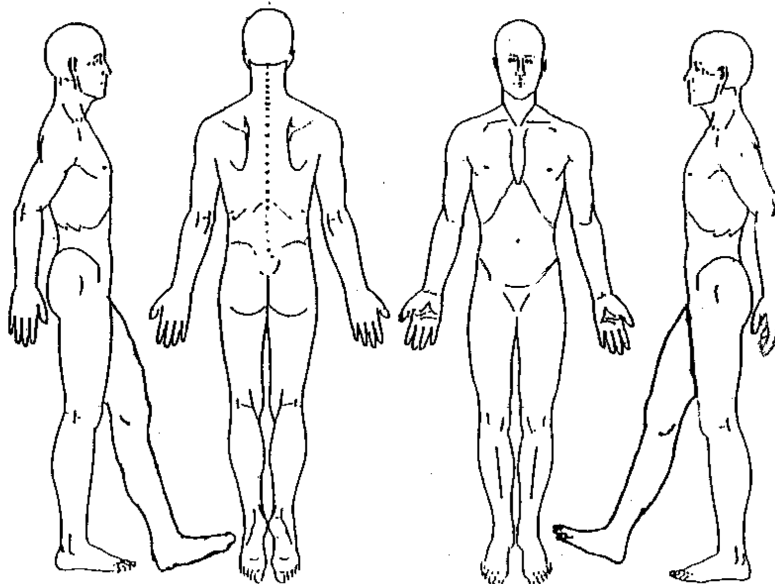
Medications you now take: ____

Herbs, home remedies, vitamins: ____

ANY KNOWN ALLERGIES TO MEDICATIONS: ____

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

PLEASE INDICATE AREAS OF DISCOMFORT/ PAIN



General Health History

Height:____________ Weight:___________ lbs. Weight 1 year ago:_________________________ lbs.
Maximum Weight:________________________ When:_______________________________________

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

Do you drink alcohol? Y / N How many drinks per day/week? ____
Do you smoke cigarettes/chew tobacco? Y / N How much? ____
Do you take recreational drugs? Which ones and how frequently? ____

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

Pain relievers	Y N P	laxatives	Y N P	Appetite suppressants	Y N P
Antacids	Y N P	Cortisone	Y N P	Sleeping pills	Y N P
Acid blockers	Y N P	antibiotics	Y N P	Thyroid medication	Y N P

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 (include year):

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

Are you hypersensitive or allergic to….
Any drugs?____
Any foods?____
Environmental allergens/chemicals?____

Exposures

Have you had daily or prolonged exposure to any toxic chemicals, paints, lead, mercury? Y N
If **yes**, what type and when? ____
Second hand smoke? Y N If yes, for how long? ____

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Diet

Do you follow a specific diet? Please explain:____

Typical Food Intake:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Beverages:____

Habits

Main interests and hobbies?____

Do you exercise? Y / N If yes, what kind? ___________________________How often?________________

Average 6-8 hrs. sleep? Y N — Enjoy your work? Y N

Sleep well? Y N — Take vacations? Y N

Awaken rested? Y N — Spend time outside? Y N

Have a supportive relationship? Y N — Watch television? Y N How many hours? ____________

Have a history of abuse? Y N

Any major traumas? Y N P — Read? Y N How many hours? ____________

Use recreational drugs? Y N P

Been treated for drug dependence? Y N P

Use alcoholic beverages? Y N P — Do you eat 3 meals a day? Y N

Treated for alcoholism? Y N P — Do you go on diets often? Y N

Do you use tobacco? Y N P — Do you eat out often? Y N

Smoked previously? Y N P — Do you drink coffee? Y N P

How many years?______ — Drink black/green tea? Y N P

How many packs per day?______ — Do you drink cola/sodas? Y N P

Do you eat refined sugar? Y N P

Do you add salt? Y N P

Do you have a religious or spiritual practice? Y / N If yes, what?______________________________

Review of Systems Please circle: Y = a condition you have 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

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

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: _______

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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

Skin

rashes	Y N P
Acne, boils	Y N P
Color changes	Y N P
Dry skin	Y N P
Eczema	Y N P
Itching	Y N P
Hives	Y N P

Neurological

Seizures	Y N P
Muscle weakness	Y N P
Vertigo, dizziness	Y N P

Blood/ Peripheral Vascular

Easy bleeding	Y N P
Easy bruising	Y N P
anemia	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

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:		

Thank you. I look forward to meeting your goals for this visit and to helping you 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 in Oregon 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 training in body-mind-spirit integration techniques for improved lifestyle strategies)
- Prescription drugs

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 sterilized disposable stainless steel needles through the skin into underlying tissues at specific points on the body's 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)
- Qi Gong, Tai Qi (slow movement exercises designed to improve specific health conditions)
- Shiatsu, Tuina (massage techniques along meridian pathways to stimulate the flow of Qi)

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 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____

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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____