



Dr. Sierra Breitbeil ND

Methow Valley Wellness Center • DrSierra@methownet.com

105 Norfolk Rd, Mail: 31 Hi Way, Winthrop, WA 98862 • 509-996-3970 • Fax: 888-672-2468

Your first visit with Dr. Sierra Breitbeil N.D. is scheduled for: Date _____ Time _____

Please bring your completed intake form to your appointment. You can also bring along any health records you have and a list of any natural or prescription medications you are taking. You might want to write down any thoughts and/or questions regarding your current state of health, challenges and/or goals you may have. Bring a diary of your food intake in the last five days prior to your appointment.

Dr. Breitbeil is a preferred provider with most major WA state health care insurance companies. We would be glad to bill them for your visit. Please call your insurance provider to ask whether your policy covers naturopathic medicine. We can also obtain this information on your behalf. Please let us know if you need assistance.

The natural medications and supplements we carry in our pharmacy are not covered by insurance. Payment for any items you purchase as well as any co-payments or deductibles on your health insurance is due at the time services are rendered. We accept cash, check, or credit cards (Visa, Master Card or American Express).

If you have any questions about insurance, payment or any other general questions about our services, please call Michael.

If you need to change your appointment day or time, please give us 24 hours notice. You will be charged for appointments missed or canceled without sufficient notice.

We are looking forward to meeting you.

Thank you.

Sincerely,

Dr. Sierra Breitbeil, ND

Directions to The Methow Valley Wellness Center in Winthrop:

Coming West on Hwy 20 from Twisp, you will enter the Winthrop town limits, pass the Post Office and Red Apple Market on the right. In less than ½ mile you will come to a Y, turn left at White Ave. (Twin Lakes Road), then take the next left onto Norfolk Rd, go 500 feet and you will see our sign and our sage green building.



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Adult Intake Form

First Name _____ Initial _____ Last Name _____ M _____ F _____

Address _____ City _____ Zip Code _____

Date of Birth _____ Occupation _____

Please list only the numbers at which we may contact you:

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

How did you hear about our clinic? _____

Marital Status _____ Name of Spouse _____ # Dependents _____

Emergency Contact _____ Phone _____

Physician _____ Clinic _____ Phone _____

Physician _____ Clinic _____ Phone _____

THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN THIS OFFICE. INFORMATION WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN AUTHOURIZED IN WRITING. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What health concerns or problems brought you to our office today?

If this is a chronic illness, how long have you had this condition? _____

Who diagnosed your illness? _____

When was the diagnosis made? _____

What specialists have you seen? (Include year of consultation) _____

If you are female, are you currently pregnant? YES NO

CURRENT MEDICATIONS

List all CURRENT prescribed medications:

Drug Name _____ Dosage _____ Length Taken _____

Drug Name _____ Dosage _____ Length Taken _____

Drug Name _____ Dosage _____ Length Taken _____

Drug Name _____ Dosage _____ Length Taken _____

List all CURRENT non-prescription medications used:

List all CURRENT vitamins, minerals, herbs, etc. that you take more than occasionally:

List all PAST prescribed medications that you've taken for longer than 3 months:

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when took it and the reaction you had.

Drug Name _____ When Taken _____ Length Taken _____

Drug Name _____ When Taken _____ Length Taken _____

Drug Name _____ When Taken _____ Length Taken _____

List all known allergies _____

How many times have you been treated with antibiotics in the past 5 years? _____

FAMILY MEDICAL HISTORY

	Age	Health Problems	If deceased, cause	Age at death
Father				
Mother				
Siblings				
Children				
Grandparents				

MEDICAL HISTORY

Please check only those that pertain to you personally:

- | | | |
|--------------------------|-------------------------------|-------------------|
| Alcohol Abuse | Female Gynecological Problems | Skin Problems |
| Allergies | Gallstones | Stroke |
| Anemia | Gum/Teeth Problems | Suicide |
| Asthma | Heart Attack | Thyroid Problems |
| Arthritis | Heart Problems | Tuberculosis |
| Back, Muscle, Joint Pain | High Blood Pressure | Ulcers |
| Bladder/Urinary Problems | Kidney Problems | Venereal Disease |
| Candida | Measles | Chronic Fatigue |
| Epilepsy | Depression | Liver Problems |
| Diabetes | Overweight | Chronic Sinusitis |
| Rheumatic Fever | Psychological Problems | Cancer |
| Lung Problems | Pneumonia | Gout |
| Mononucleosis | Eczema | Bowel Disease |
| Influenza | Hay Fever | Constipation |
| Rheumatism | Pleurisy | Hives |
| Malaria | Chronic Swollen Glands | Hypoglycemia |

Blood Type _____

Date of last physical exam _____ For what reason? _____

Do you have regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) YES NO

PERSONAL HEALTH HABITS

Height _____ Current Weight _____ Weight 1 year ago _____ Max Weight _____ Year _____

Smoker? YES NO Amount/Day? _____ Years Smoked? _____ Year Stopped? _____

Are you exposed to smoking at home? YES NO Are you exposed to smoking at work? YES NO

Alcohol Use? YES NO Type _____ Frequency _____

Recreational Drug Use? YES NO Type _____ Frequency _____

Caffeine Use? YES NO Type _____ Frequency _____

Are there any food groups that you avoid? YES NO

What? _____ Why? _____

Are you frequently exposed to animals? YES NO If yes, what type? _____

Are you regularly exposed to toxins or other hazards? YES NO What kind? _____

Do you exercise regularly? YES NO Type _____ Frequency _____

How many hours do you sleep per night? _____ Do you wake rested? YES NO

How many hours do you work each day? _____ Do you do shift work? YES NO

What level of personal stress are you experiencing right now?

Minimal Average Considerable Unbearable

Your main stressor right now is? _____

What do you do to deal with stress? _____

When was your last vacation? _____ Where did you go? _____

What are your hobbies? _____

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, etc.

Years 1-5 _____

Years 6-10 _____

Years 10-15 _____

Years 16-20 _____

Years 21-25 _____

Years 26-30 _____

Years 31-35 _____

Years 36-40 _____

Years 41-45 _____

Years 46-50 _____

Years 51-55 _____

Years 55-60 _____

Years 61-65 _____

Years 66-70 _____

Years 71-75 _____

Years 76-80 _____

Years 81-90 _____

What was your mother's state of health during her pregnancy with you (if you know)? _____

How was your birth? Were there any complications? _____

SYMPTOMS REVIEW

Please check (✓) Y if you have the symptom now, and P if the symptom is in the past.

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

HEAD	Y	P
Tension headaches		
Migraine headaches		
Head injury		
Dizziness		
Other		

EYE	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stiffness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculin test		
Last TB test		
Last chest X-ray		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitation, fluttering		
Last ECG		
Other		

BREASTS	Y	P
Do you do breast self exam?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Trouble swallowing		
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

BLOOD/LYMPHATIC	Y	P
Anaemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Last prostate exam		
Last PSA level		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses		
Last menstrual period		
Number of days of menses		
Length of cycle		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of live births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		

FEMALE REPRODUCTIVE	Y	P
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Menopause		
Age of onset		
Hormone therapy		
Last gynaecological exam		
Last pap smear		
Other		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

PERIPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

EMOTIONAL	Y	P
Depression		
Angry		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		



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Insurance Information

Name _____

Address _____

Phone _____

Birthdate _____

Date of First Visit _____

Insurance Company _____

Policy Number _____

Group Number _____

Policy Holder Name (or self) _____

Policy Holder Birthdate (or self) _____

Please call your insurance company to check if your policy covers office visits to a naturopathic physician

Let us know if your need assistance. Thank you very much.

Sincerely,

Michael
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