Dr. Sierra Breitbeil ND
Methow Valley Wellness Center • SierraBreitbeil@gmail.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 _____

Dear Prospective Patient,

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

Payment is required at the time of visit. Cash, check and credit cards are accepted. There is a Fee Schedule on the MVWC website to help you to budget for your appointment.

Dr. Sierra does accept and directly bill Medicaid (Apple Health of WA.) She can bill a few other insurance companies directly; please ask if yours is included.

A patient with private insurance not directly billed by Dr. Sierra may choose to send a claim to their company. This is called a patient submitted claim. Receiving reimbursement from a medical insurance company is subject to their policies.

Patients will receive a receipt and can also request a "super bill" which contains diagnosis and treatment codes. It also shows that the patient has paid for the visit. To submit a claim one must download (from the insurance companies website) a patient submitted claim form, fill it out, include a copy of the superbill and a copy of both sides of their insurance card. All is mailed to the address on the form. We are happy to help with any questions you have about submitting your claim.

Patients who have Health Savings Accounts or Flex Spending Accounts can pay with their HSA or FSA credit cards or checks.

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

We are looking forward to meeting you. Thank you.

Sincerely,

Dr. Sierra Breitbeil, ND

Directions to The Methow Valley Wellness Center in Winthrop:
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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Child Intake

Child's Name _____Date of Birth _____ Sex M F

Child's Address _____ Child's Phone _____

Who is filling out this form? Name _____ Relationship _____

Referred by _____

Contacts (in order of preference)

1. Name _____ Phone (H) _____

   Address _____ (W) _____

   _____

Relationship to Child _____

2. Name _____ Phone (H) _____

   Address _____ (W) _____

   _____

Relationship to Child _____

Whom does the child live with? _____

Other health care providers

1. _____ 2. _____ 3._____

_____ _____ _____

Phone #_____ Phone #_____ Phone #_____

What are your child's health concerns, in order of importance:

1. _____

2. _____

3. _____

4. _____

Child's Medical History

Please indicate any serious conditions, illness or injuries, and any hospitalizations, along with approximate dates:

_____

_____

_____

_____

Which of the following diseases has your child had?

☐Rubella (German measles)	☐Roseola	☐Impetigo
☐Measles	☐Scarlet Fever	☐Mononucleosis
☐Chicken pox	☐Strep throat	☐Ear Infections
☐Whooping cough	☐Mumps	

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all CURRENT medication (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

_____

_____

_____

_____

Please list all PAST prescription medications.

_____

_____

_____

_____

How many times has your child been treated with ANTIBIOTICS? _____

Which of the following immunizations has your child had?

☐DPT(diphtheria, pertussis, tetanus)	☐Haemophius influenza	☐Hepatitis B
☐Tetanus booster: when? _____	☐"Flu"	☐Hepatitis A
☐MMR(measles, mumps, rubella)	☐Polio	☐Chicken Pox
☐Other _____	☐HPV	☐Rotavirus

Please indicate if any of the above have caused an adverse reaction:

_____

_____

Has your child had any screening test (i.e. blood, hearing, vision)? ☐Yes ☐No
If yes please list:

_____

_____

Child's Diet

How was your infant fed?

☐Breast-fed: how long? _____ ☐Formula: ☐Milk ☐Soy ☐Other

☐Other: _____

Where foods introduce before 6 months? ☐Yes ☐No

If yes please list:

_____

_____

What foods were introduced between 6-12 months?

_____

_____

_____

Did your child ever experience colic? ☐Yes ☐No

Was it? ☐Mild ☐Moderate ☐Severe

Does your child have any food allergies or intolerances? ☐Yes ☐No

If yes please list:

_____

_____

Does your child have any dietary restrictions (i.e. religious, vegetarian/vegan)? ☐Yes ☐No

If yes please list:

_____

_____

Describe a typical day's diet for your child

Breakfast _____ Snacks _____

Lunch _____ Beverages:

Dinner _____ Type? _____

How many? _____

Health and Development

How was your child's health in the first year? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern:

_____

Describe your child's temperament:

_____

Describe your child's behaviour and performance at school:

_____

_____

Prenatal Health

What was the health of the parents at conception?

Mother: ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Father: ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the health of the mother during the pregnancy?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

How was the mother's diet during pregnancy ?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the mother's age at the time of this child's birth? _____

Did the mother receive prenatal medical care? ☐Yes ☐No ☐Unknown

Did the mother experience any of the following during the pregnancy:

☐Bleeding ☐High Blood Pressure ☐Nausea ☐Vomiting

☐Diabetes ☐Thyroid Problems ☐Physical Trauma ☐Emotional trauma

☐Other:_____

Did the mother use any of the following substances during the pregnancy?

☐Recreational drugs: Type? _____

☐Prescription Medications: List? _____

☐Over-the-counter Medications: List? _____

☐Supplements: List?_____

☐Tobacco ☐Alcohol ☐Other: _____

Birth History

Term Length: ☐Full ☐Premature: _____wks. ☐Late: _____wks.

Length of labour: _____ Child's weight at birth: _____

Was the birth: ☐Vaginal ☐C-section ☐Induced ☐Forceps ☐Anesthesia used

Where they're any complications? ☐Yes ☐No

If yes explain?

_____

_____

Did the child experience any of the following at or shortly after the birth?

☐Jaundice ☐Rashes ☐Seizures

☐Birth injuries: _____ ☐Birth defects:_____

☐Other:_____

Family History

Do you know the family medical history? ☐Yes ☐No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Who & Relationship	Symptoms	Who & Relationship
Allergies		Birth defects	
Asthma		Juvenile arthritis	
Diabetes		Other	
Kidney disease			

Do either of the parents have a chronic illness? ☐Yes ☐No
If yes please describe.

_____

_____

Child's Environment

Is the child in? ☐School ☐Daycare ☐Home care ☐Other

What are the child's favourite activities?

_____

_____

Does the child exercise regularly? ☐Yes ☐No
How much? _____
How often? _____

How much television doe your child watch? _____ hrs. per day/week

How often does your child read, or is read to (not for school)?
☐Daily ☐Several times a week ☐Weekly ☐Less than weekly ☐Never

Does anyone in the child's household smoke? ☐Yes ☐No

Are there any animals in the home? ☐Yes ☐No
What kind? _____

How is the child's home heated? _____

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)? Please describe:

_____

_____

How would you describe the emotional climate of the child's home?

_____

_____

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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
Methow Valley Wellness Center
509-996-3970
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