Juliette Soihl, ND, LMT
Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

ADULT INTAKE

Full Legal Name: LAST ____________________________, FIRST____________________________M.I.____
Name I Prefer to Go By ____________________________ Occupation ____________________________________
Today's Date (1st Appt.) ____/____/____ AGE____ Date of Birth____/____/____
Gender Identification:__________________________ Phone:____
Street Address ____ City__________________________________
State_______________ Zip Code__________________ E-Mail____
( )Single ( )Married ( )Partnered Name of partner/spouse: ____
Emergency Contact__________________________ Phone__________________ Relationship__________________

INSURANCE INFORMATION

Insurance Co. Name____________________________ Subscriber ID #____________________________
Name of Insured______________________ Relationship______________ Insured DOB__________________
Insurance Co. Toll Free Phone #____________________________Group #____________________________
Related to Auto Accident?___If Yes, Who is handling your Personal Injury Claim__________________
Date of Injury___/___/20__ Their phone # ____________________ Fax______________________________
Auto Claim #____________________________ Auto Insurance Policy # ____________________________

Patient Insurance Billing Agreement:

I hereby authorize my insurance benefits with _____________________(Insurance Co. Name) to be paid directly to Juliette Soihl, N.D. at 5010 NE 33rd Ave, Portland, OR 97211. I agree to pay any *co-payments and/or the percentage of treatment costs not covered by my insurance*, on the day of each appointment. I am financially responsible for the fees for all services that are not paid in full by my insurance benefits within 90 days of initial billing, including non-covered services. I authorize the release of any information necessary to process this claim.

Signature of Patient: ____ Date ____/____/20________

INTAKE

What expectations do you have of me personally as your health care provider? ____________________________
____
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, 10 being 100% committed.
0% 0 1 2 3 4 5 6 7 8 9 10 100%
What behaviors do you currently engage in that you believe support your health? ___________________________
____
What behaviors do you currently engage in that you believe do not support your health? ____________________
____
What potential obstacles do you foresee in addressing the factors that may need to change to enhance your health?____
Who do you know that could sincerely support you with the beneficial changes you could make?
____

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Your Primary Care Doctor___________________________________ Phone________________
Date last seen and Reason____
Other Healthcare Provider___________________________________ Phone________________
Date last seen and Reason____
Other Healthcare Provider___________________________________ Phone________________
Date last seen and Reason____

What are your most important health problems? List as many as you can in order of importance.
1) ____
2) ____
3) ____
4) ____
5) ____
6) ____
7) ____
Do you have any known contagious diseases at this time? Yes / No
If yes, what? ____

FAMILY HISTORY
Do you have a family history of any of the following (please circle)?

High Blood Pressure	Diabetes	Cancer	Tuberculosis	Asthma/Eczema
Heart Disease	Kidney disease	Epilepsy	Arthritis	Hay fever/hives
Heart murmur	Glaucoma	Stroke	Mental Illness	Anemia

Is your father still living? Yes; his age ____ No; age at time of death ____ Cause of death_____
____
Is your mother still living? Yes; her age ____ No; age at time of death ____ Cause of death_____
____
Any other relevant family history? ____
____
What is your family heritage? ____

CHILDHOOD ILLNESSES
Please circle whether you have/had any of the following as a child:

Chicken pox	Diptheria	German measles	Measles
Rheumatic fever	Mumps	Scarlet fever	Other ______________

HOSPITALIZATIONS/SURGERY/IMAGING
What hospitalizations, surgeries, x-rays, CAT scans, MRI's, EEGs, EKGs have you had?
___________________________ Year ______ ___________________________ Year ______
___________________________ Year ______ ___________________________ Year ______
___________________________ Year ______ ___________________________ Year ______

ALLERGIES
Are you hypersensitive or allergic to:
Any drugs? ____
Any foods? ____
Any environmental agents or chemicals? ____
____

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CURRENT MEDICATIONS
Do you take or use any of the following (please circle):

Laxatives	Pain Relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping pills	Thyroid medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:
1) ________________________ 5) ________________________
2) ________________________ 6) ________________________
3) ________________________ 7) ________________________
4) ________________________ 8) ________________________

GENERAL
Height: ______________Weight: ______________ Weight one year ago:____________
Maximum Weight: ______________ When: ______________
When during the day is your energy the best? ______________ Worst? ______________
Main interests and hobbies: ______________
Exercise: Y / N If so, what kind and how often: ______________
Watch TV: Y / N If so, how many hours? ____Read: Y / N If so, how many hours? __________
Do you have a religious or spiritual practice? Y / N If so, what kind? ______________

TYPICAL FOOD INTAKE
Breakfast: ______________
Lunch: ______________
Dinner: ______________
Snacks: ______________
To drink: ______________

FOR THE FOLLOWING, PLEASE CIRCLE:
Y = Yes N = No P = Problem in the Past

GENERAL		RESPIRATORY	
Do you sleep well?	Y N	Cough?	Y N P
Average 6-8 hours?	Y N	Coughing up blood?	Y N P
Awake rested?	Y N	Pneumonia?	Y N P
Have a history of abuse?	Y N	Asthma?	Y N P
Experienced a major trauma?	Y N	Wheezing?	Y N P
Use recreational drugs?	Y N P	Bronchitis?	Y N P
Treated for drug dependence?	Y N P	Difficulty breathing?	Y N P
Consume alcoholic beverages?	Y N P	Shortness of breath?	Y N P
Use tobacco?	Y N P	Pain on breathing?	Y N P
If in the past, how many years? _______		Emphysema?	Y N P
How many packs per day? _______		Tuberculosis?	Y N P

IMMUNE		HEAD	
Reactions to immunizations?	Y N P	Headaches?	Y N P
Slow wound healing?	Y N P	Migraines?	Y N P
Chronic fatigue syndrome?	Y N P	Head injury?	Y N P
Chronic infections?	Y N P	Jaw or TMJ problems?	Y N P
Night sweats?	Y N P		

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ENDOCRINE

Hypothyroid?	Y N P
Hyperthyroid?	Y N P
Hypoglycemia?	Y N P
Excessive thirst?	Y N P
Fatigue?	Y N P
Heat or cold intolerance?	Y N P
Diabetes?	Y N P
Excessive hunger?	Y N P
Seasonal depression?	Y N P

EARS

Impaired hearing?	Y N P
Ringing in ears?	Y N P
Dizziness?	Y N P
Ear aches?	Y N P

EYES

Impaired vision?	Y N P
Cataracts?	Y N P
Glaucoma?	Y N P
Tearing or dryness?	Y N P
Eye pain or strain?	Y N P

NOSE AND SINUS

Frequent colds?	Y N P
Sinus problems?	Y N P
Hayfever?	Y N P
Loss of smell?	Y N P

NECK

Enlarged Glands	Y N P
Goiter?	Y N P
Difficulty swallowing?	Y N P
Pain or stiffness in neck?	Y N P

MOUTH AND THROAT

Frequent sore throat?	Y N P
Teeth grinding?	Y N P
Gum problems?	Y N P
Dental cavities?	Y N P
Root Canal?	Y N P

CARDIOVASCULAR

Heart disease?	Y N P
Angina?	Y N P
High/Low blood pressure?	Y N P
Heart murmus?	Y N P
Fainting?	Y N P
Palpitations/fluttering heart?	Y N P
Chest pain?	Y N P

GASTROINTESTINAL

Trouble swallowing?	Y N P
Change in thirst?	Y N P
Change in appetite?	Y N P
Nausea/vomiting?	Y N P
Gall bladder disease?	Y N P
Liver disease?	Y N P
Hemorrhoids?	Y N P
Abdominal pain or cramps?	Y N P
Belching or passing gas?	Y N P
Constipation?	Y N P

Bowel movments: how often? ________

Anorexia/Bulimia	Y N P

FEMALE REPRODUCTIVE

Age of first menses: ________________

Age of last menses (if menopausal): ____

Length of cycle: _______________ days

Duration of menses: ____________ days

Are your cycles regular?	Y N P
Painful menses?	Y N P
Heavy or excessive flow?	Y N P
PMS?	Y N P

Symptoms: ____________________________

Bleeding between cycles?	Y N P
Endometriosis?	Y N P
Ovarian cysts?	Y N P
Vaginal yeast?	Y N P
Vaginal discharge?	Y N P

Date of last pap smear: _______________

Abnormal PAP?	Y N P
Cervical dysplasia?	Y N P
Are you sexually active?	Y N P

Sexual orientation: __________________

Birth control? Type: ________________

Pain during intercourse?	Y N P
Gonorrhea/Chlamydia?	Y N P
Herpes (HSV1 or 2)?	Y N P
Genital warts?	Y N P
Syphilis?	Y N P
Difficulty conceiving?	Y N P

Number of pregnancies: ______________

Number of live births: ________________

Number of miscarriages: ______________

Number of abortions: _________________

Do you do self breast exams?	Y N P
Breast pain/tenderness?	Y N P
Breast lumps?	Y N P
Nipple discharge?	Y N P
Menopausal symptoms?	Y N P

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SKIN

Rashes? Y N P
Acne/boils? Y N P
Eczema or hives? Y N P
Itching? Y N P
hair loss? Y N P

URINARY

Pain on urination? Y N P
Frequency at night? Y N P
Frequent UTIs? Y N P
Kidney Infection? Y N P
Kidney stones? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P
Arthritis? Y N P
Weakness? Y N P
Muscle spasms or cramps? Y N P

BLOOD

Anemia? Y N P
Easy bleeding or bruising? Y N P
Cold hands/feet? Y N P
Deep leg pain? Y N P
Varicose veins? Y N P

MALE REPRODUCTIVE

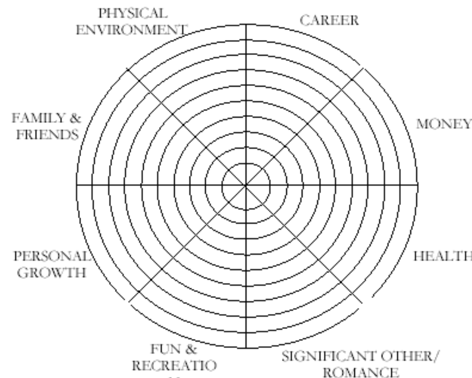
Are you sexually avitve? Y N P
Sexual orientation: ___________________
Birth control? Type: _________________
Discharge or sores? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Genital warts? Y N P
Herpes? Y N P
Syphilis? Y N P
Hernias? Y N P
Testicular masses? Y N P
Testicular pain? Y N P
Prostate disease? Y N P
Erectile Dysfunction? Y N P
Premature ejaculation? Y N P

MENTAL/EMOTIONAL

Therapy/Counseling Y N P
Depression? Y N P
Anxiety or nervousness? Y N P
Poor concentration? Y N P
Mood swings? Y N P
Considered suicide? Y N P
Memory problems? Y N P
Taken Anti-depressants? Y N P
Taken Anxiolytics? Y N P

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are 60% satisfied in your career, shade the first six levels of the career slice. Do the same for each area, starting from the center point radiating outward.



Thank you for your time and effort. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so at the side of this page.

How did you hear about me? ( )From a Friend ( )Website ( )Insurance Company ( )Practitioner/Other Referral
( )Flyer/Business Card ( )Other________________________________

Juliette Soihl, ND, L.M.T. ~ 5010 NE 33rd Ave ~ Portland, OR 97211 ~ (503) 238-1065 ~ www.renewedhealthnow.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES.

I. How we may use and share health data about you:
a) Treatment – To give you medical treatment or other types of health services.
b) Payment – To bill you or a third party for payment for services provided to you.
c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected.
d) Public health risks (for public health activities to prevent and control spread of disease).
e) Lawsuits and disputes (in response to a court or administrative order).
f) Law enforcement (to help law enforcement officials respond to criminal activities).
g) Coroners, medical examiners, and funeral directors.
h) Organ or tissue donation facilities if you are an organ donor.
i) To avert a threat to an individual or to public health safety.

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment of your care – We may share your health data with a family member, close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request.
b) Right to amend information in your health record you believe is inaccurate or incomplete.
c) Right to know to whom we have disclosed your health information.
d) Right to ask for limits on the health information data we give out about you.
e) Right to receive communication from us about your health information in alternate ways.
f) Right to a paper copy of the complete Notice of Privacy Practices.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

______________________________	____________________	________________	______________
Signature of patient or representative	Print patient name	Date	Patient Birth Date

CONSENT TO TREATMENT

I, the undersigned, understand that methods of evaluation used in this practice may include, but are not limited to, physical exams (vitals, musculoskeletal, EENT, heart and lung, orthopedic, dermatologic, and neurological assessments) and diagnostic procedures (including venipuncture, diagnostic imaging, and laboratory evaluation of blood, urine, stool, and saliva).

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, naturopathic medicine, herbal therapy, homeopathy, massage, hydrotherapy, nutritional supplements, pharmaceutical prescriptions, sauna therapy, and lifestyle and nutritional counseling. I understand that naturopathic medicine, herbal therapy, homeopathy, massage, hydrotherapy, nutritional supplements, pharmaceutical prescriptions, sauna therapy, and lifestyle and nutritional counseling are safe methods of treatment. Potential risks are uncommon but may include nausea, headache, stomachache, vomiting, diarrhea, rashes, hives, or dizziness. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.
I will notify Dr Juliette Soihl should I become pregnant or if I am in the process of trying to get pregnant so that she can avoid medications, supplements, and herbs that could induce miscarriage. Otherwise, Naturopathic medical treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to my by Dr Juliette Soihl are safe in the recommended doses. Large doses of herbs or supplements taken without my practitioner's recommendation may be toxic, and some herbs and supplements are inappropriate during pregnancy. Some possible side effects of herbs or supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and dizziness. I understand that if I experience any adverse effects from herbs, supplements, or medications prescribed by Dr Juliette Soihl that I must stop taking these herbs, supplements, or medications and notify Dr Juliette Soihl as soon as I experience any discomfort or adverse reactions.

I understand that Dr Juliette Soihl may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the situations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with Dr Juliette Soihl before signing if I so choose. However, I do not expect Dr Soihl to be able to anticipate and explain all possible risks and complications of treatment. I rely on Dr Juliette Soihl to exercise judgement in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. A fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. In signing this form, I acknowledge any inherent risks, give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

______________________________	______________________________
Patient Signature	Date