

NEW PATIENT PACKET

Welcome To Our Clinic!

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Shipping address: _____
Home phone: (_____)_____-_____ Cell phone: (_____)_____-_____
E-mail: _____

Date of Birth:_____ Age:_____ Gender: F / M / MTF / FTM
Height:_____ Weight:_____ Pronouns: _____

Marital Status: S M D W

Occupation:_____Employer:_____

Emergency Contact: _____Phone: _____
Relationship: _____

HOW DID YOU HEAR ABOUT US?

_____

Please rate your overall level of health (circle one): Excellent / Good / Fair / Poor

What are your most important health concerns? List in order of importance.

1.)_____Onset: _____

2.)_____Onset: _____

3.)_____Onset: _____

4.)_____Onset: _____

5.)_____Onset: _____

Name and location of current physician(s): _____

Dr. Heather Sorber, ND and Dr. Margaret Ptak, ND LAc
525 N. Columbia River Hwy., Saint Helens OR 97051
Phone: 503-410-3134 Fax: 503-893-3118

Date of last:

Physical _____	Blood test _____
Female exam _____	Prostate exam _____
Dental visit _____	Massage _____
Chiropractic visit _____	Acupuncture visit _____
Naturopathic visit _____	Mammogram _____

ALLERGIES

List all drug, food and environmental allergies: _____

_____

PAST MEDICAL HISTORY

List any major illnesses with approx. dates: _____

_____

List any surgery or operations with approx. dates: _____

_____

Past accidents or injuries: _____

_____

FAMILY HISTORY

Please list any medical conditions that run in your family (parents, siblings, grandparents, aunts and uncles): _____

_____

_____

Cigarette smoking: ___Past ___Present ___No smoking history

Cigarettes: _____ # each day x _____ total years smoking

Coffee/tea: _____ ounces daily (1mug=14oz)

Alcohol: _____ # of beers, glasses of wine and hard alcoholic drinks per week

Recreational drug usage: _____

Exercise: _____

Medications/supplements currently taking (please include dosage): _____

_____

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DIETARY INTAKE 2 DAYS PRIOR TO VISIT

Day One

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other drinks:

Day Two

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other drinks:

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Patient Survey

Please rate how serious you are about getting well
0 1 2 3 4 5 6 7 8 9 10
Not serious Very serious

Are you willing to take nutritional and/or homeopathic supplements?
Yes
No

Are you willing to make dietary changes?
Yes
No

Are you willing to follow a treatment program designed to return you to health by treating the cause?
Yes
No

Are you familiar with Applied Kinesiology?
Yes
No

Please rate your current stress level on a scale
0 1 2 3 4 5 6 7 8 9 10
No stress Maximum Stress



Clinic Policies & Agreements

Please read each section carefully and initial where indicated.

1. Payment Agreement

I understand that payment is due at the time of service for any services, tests, or medicinary items not covered by insurance. I acknowledge that a $25 fee will apply to any returned checks. All major credit cards are accepted.

Initial: _____

2. Medicinary Product Return Policy

For safety and quality assurance, once medicinary products (including supplements, homeopathics, and botanicals) leave the clinic, they cannot be returned or refunded.

Initial: _____

3. Cancellations & Missed Appointments

I agree to notify the clinic at least **24 hours in advance** if I need to cancel or reschedule an appointment. I understand that I will be charged a **$60 missed appointment fee** if I fail to do so.

Initial: _____

4. Email Communication

I understand that while email may be used for convenience in communication, it is not encrypted and may carry privacy risks. By initialing, I consent to the use of email for communication with my provider and other care team members involved in my treatment.

Initial: _____

5. Fragrance-Free Policy

To help maintain a safe and comfortable environment for all patients and staff, I agree to refrain from wearing perfume, cologne, heavily scented lotions, essential oils, or other fragranced products during clinic visits whenever possible. I understand that some individuals may experience sensitivities or allergic reactions to fragrances.

Initial: _____



6. Consent to Use AI Technology for Clinical Scribing

I understand that the clinic may use secure AI-assisted technology during appointments to help document clinical notes and summaries. This technology functions only as a documentation aid ("scribe") and does not replace professional medical judgment, diagnosis, or treatment decisions.

I understand that all documentation will be reviewed and approved by my provider and that my information will be handled in accordance with applicable privacy and confidentiality laws.

By initialing below, I consent to the use of AI-assisted scribing technology as part of my care.

Initial: _____

Acknowledgment of Clinic Policies

I have read and understood the clinic policies above and agree to comply with them. I also consent to the release of my medical records to my insurance provider as required for billing and coordination of care.

Print Name: _____
Signature: _____
Date: _____

Informed Consent

Please read carefully before signing.

Naturopathic medicine and acupuncture use a variety of natural and integrative therapies intended to support the body's inherent ability to heal. While these methods are generally safe and effective when provided by a licensed practitioner, all treatments carry potential risks, and results cannot be guaranteed.

Therapies That May Be Used

Your care may include, but is not limited to, the following therapies:

- Nutritional supplements, botanical medicine, Chinese herbal medicine, and homeopathy
- Lifestyle counseling, dietary recommendations, and health education
- Naturopathic manipulative therapy and other physical medicine techniques
- Applied kinesiology, a clinical assessment method using gentle manual muscle testing as one component of evaluating functional imbalances in the body
- Acupuncture and traditional Chinese medicine techniques, including the use of sterile, single-use needles and moxibustion (the application of heat from burning herbal preparations near or on acupuncture points)
- Cupping therapy, which uses suction applied to the skin to support circulation and relieve muscle tension; temporary skin discoloration may occur
- Infrared light therapy, a non-invasive therapy using specific wavelengths of light to gently warm tissues and support circulation and relaxation
- Injection therapies, which may include vitamins, minerals, botanical substances, homeopathic remedies, or other substances within the practitioner's scope of practice
- Physical examinations and laboratory testing

Potential Risks May Include:

- Allergic reactions, sensitivities, or side effects related to supplements, herbs, injectable substances, or topical preparations
- Discomfort, bruising, bleeding, soreness, dizziness, or fainting associated with acupuncture or injection therapy
- Temporary worsening of symptoms or fatigue following treatment
- Infection, inflammation, or nerve irritation (rare) associated with needling or injections
- Interaction between naturopathic treatments and prescription or over-the-counter medications (please disclose **all** medications and supplements you are taking)

Alternatives:
I understand that alternatives to naturopathic and Chinese medicine care may include conventional medical treatment, other complementary therapies, or choosing no treatment at all.

Allergies:
Please list any known allergies or sensitivities (including medications, herbs, latex, or foods):

_____

_____

Consent:
I understand that naturopathic and Chinese medicine care is **not a guaranteed cure**, and that outcomes vary by individual. I have had the opportunity to ask questions about my care, and all of my questions have been answered to my satisfaction. I voluntarily consent to evaluation and treatment, and I authorize my provider to use their best clinical judgment in my care.

Print Name: _____
Signature of Patient or Parent/Guardian: _____
Date: _____



HIPAA Notice & Communication Preferences

We are committed to protecting your personal health information (PHI) as required under the **Health Insurance Portability and Accountability Act (HIPAA)**. Your information may be used for purposes such as:

- Coordinating care with other providers
- Communicating with your designated family members or caregivers
- Submitting insurance claims and obtaining payment
- Reporting certain public health concerns (e.g., flu outbreaks)
- Legal requirements (e.g., reporting gunshot wounds)

Please indicate your communication preferences:

(✓ or X all that apply)

☐ You may call me at home
☐ You may call my mobile phone
☐ You may leave a voicemail

☐ You may text me
☐ You may email me regarding my care
☐ You may send bills and medical correspondence by mail

Alternate phone number(s): _____
Alternate address (for billing or mail):

Other requests regarding communication or privacy:

Print Name: _____
Signature of Patient or Guardian: _____
Date: _____

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