Dr. Hilary Back, LLC

Naturopathic Doctor • Licensed Acupuncturist • Chinese Herbalist

"Empowering People to Live Their Lives Fully"

Dear New Client:

It is extremely helpful if you prepare some information before your first appointment, to ensure that the visit is as thorough and useful as possible. Enclosed is a questionnaire and a diet diary form. Please complete the questionnaire and fill out the diet diary for any three days in a row between now and your scheduled visit. The diet diary is both a list of what you eat meal by meal and brief notes on how you felt on those days. If existing symptoms are worse at any particular time, please note when.

If another physician has ordered laboratory work in the previous twelve months, please call their office and ask that a copy of the results be sent either to you or to me, hopefully before the first visit.

Thank you for putting your time into this preparation. Please remember to bring it with you to your appointment on _____ at_____. These forms greatly facilitate the visit.

If you need to cancel this appointment, please call 24 hours in advance. Barring emergencies, there will be a $120 charge for missed first appointments that are not canceled 24 hours in advance.

I look forward to meeting,

Sincerely,

Hilary Back, ND., LAc.

20 N. 4th Street • Carbondale, CO 81623 • **(970) 963-6500 • Fax (970) 963-2950**

www.drhilaryback.com

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DISCLOSURE FORM

Hilary Back, N.D., L.Ac., obtained her degrees from National College of Naturopathic Medicine (6/00). She received a Doctor of Naturopathic Medicine and a Masters of Science in Oriental Medicine. The program is a four-year doctorate and a three-year masters program, completed simultaneously in five years. She received a Diplomat of Acupuncture from the NCCAOM (7/00). She is a member of NCCAOM as well as the AANP and the CANP. She is licensed in the state of Colorado for acupuncture, license # 637; she is also a licensed naturopathic doctor in the state of Oregon, license # 1088. Dr. Back has been trained to treat with acupuncture, Chinese herbs and Qi gong, as well as all naturopathic modalities.

Fee Schedule: an Initial Consult is 1 – 1 ½ hours at a rate of $170 per hour. All Prices are based on the length of time for the visit. If visit exceeds expected time you will be charged accordingly. Follow up appointments are: ½ hour for $85, ¾ hour for $130, and a one hour follow up for $170. Follow up acupuncture visits are $85. Follow up acupuncture visits with an adjustment are $130. Cosmetic Acupuncture is $150 per session.

Consultation phone calls will be charged at $15 per five minutes. Excessive time spent reading letters, e-mails, faxes and responding to them will be charged at $15 per 5 minutes.

All clients are asked to pay in full at the time of visit, even if you have insurance coverage. We will provide you receipts to send into your insurance carrier for your reimbursement.

24 Hour notice is required for all cancellations. The first time you will be billed half of your appointment fee. Future cancellations in less than 24 Hours will be billed in full. All expenses for supplements and herbs are in addition to the cost of the treatment.

Dr. Hilary Back is in full compliance with all rules and regulations of the Department of Health, using disposable stainless steel needles in the practice of acupuncture and proper sanitation of the acupuncture offices. None of Dr. Back's licenses, certificates, or registrations has ever been revoked. As a patient, you are entitled to receive information about the methods of therapy, techniques used, and duration of therapy if it can be determined. You may seek a second opinion from another health care professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies. The practice of acupuncture is regulated by the Department of Regulatory Agencies. The address and phone number for the complaints and investigation section is: 1560 Broadway, Suite 1545, Denver, CO 80202. Bruce M. Douglas, Director of the Division of Registrations can be reached at (303) 894-2464.

I have read the above information and my signature endorses my understanding of the conditions.

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used.

Dr. Hilary Back, LLC uses health information about you for treatment, to help you obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Dr. Hilary Back, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Dr. Hilary Back, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.

Dr. Hilary Back, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function and in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy or your health records, request a communication of your information by alternative means at alternative locations, or revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer (Dr. Back's office manager) and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Dr. Hilary Back, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for any reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr. Back's office manager at (970) 963-6500

_____ _____

Patient Signature Date

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CONSENT FOR TREATMENT

I _____ have been advised of my diagnosis of my current condition by my M.D. or D.O. and recognize that I have the option of current medical treatment for my condition. I understand that although naturopathic doctors are licensed as primary-care health care providers in many states, they are not currently licensed in the state of Colorado. All recommendations and natural treatments suggested are not intended to be a substitute for diagnosis of a specific medical condition or to replace conventional treatment as prescribed by an M.D. /D.O., or other primary care provider.

I, the undersigned, herby request and consent to the performance of acupuncture and other naturopathic practices recommended by Dr. Hilary Back, N.D., L.Ac. including, but not limited to moxibustion, cupping, electro-acupuncture, herbal medicines, homeopathy, nutritional supplements, naturopathic manipulation and cranial sacral therapy. This consent includes the above treatments by any Naturopathic Doctor or Licensed Acupuncturist working with Dr. Back, in her office, and any substitute recommended in Dr. Back's absence.

Potential Risks: discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to the treatment, occasional mood changes, rarely neurological injury. There have also been instances reported of scarring, spontaneous miscarriage, and pnueomothorax. Serious injury has been reported in literature as rare complications of some of these procedures.
Potential Benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention or elimination of the presenting problem.

I have had the opportunity to discuss with Dr. Back and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electro-acupuncture, herbology, physiotherapy, homeopathy and other procedures. I understand that there are no guarantees regarding cure or improvement of my condition.
I understand and am informed that there are some risks to acupuncture, oriental medicine, and natural remedies, such as those listed above. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the doctor/acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the supplements, I will inform the doctor. I will also inform the N.D., L.Ac. of any changes or new conditions that I become aware of in my health.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to treatment with Dr. Back. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment.

I hereby release Hilary Back, N.D., L.Ac. from all liability which may occur in connection with the above mentioned procedures, except for failure to act as a reasonably careful naturopathic doctor and licensed acupuncturist.
I understand that I am free to withdraw my consent and discontinue participation at any time.

_____ _____
Signature of Patient (or legal guardian) Relationship to patient

_____ _____
Print Name of Patient (or legal representative) Date

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Name _____ Date of First Visit_____

Physical Address_____

Mailing Address _____

City_____ State_____ Zip Code_____

Telephone # (home)_____ (work)_____(cell) _____

E-mail_____ Fax # _____

Age_____ Date of Birth (M/D/Y)_____ Gender: female____ male____

Occupation_____ Hours per week____ Employer_____

Marital Status_____ Social Security #_____

If child, parents names _____

Next of kin or other to reach in an emergency_____

Relationship_____ Phone # _____

HEALTH OVERVIEW

Name of current general practitioner (MD/DO) _____
GP's contact information _____
When was your last visit to your GP? _____
What was the reason?_____
Are you seeing a medical specialist? Yes No
If yes, for what reason? _____
Name of specialist _____
Do you have any known contagious diseases at this time? Yes No If yes, what?_____
What is the main reason for your visit today? _____
_____
What are your most important health problems? List as many as you can in order of importance.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Referred by? _____

HEALTH HISTORY QUESTIONAIRE

FAMILY HISTORY

Do you have a family history of any of the following (please circle and indicate which relative(s)?

Cancer _____ Diabetes _____ Heart Disease _____
Kidney Disease _____ Epilepsy _____ High Blood Pressure _____
Tuberculosis _____ Stroke _____ High Cholesterol _____
Asthma/Hayfever/Hives ___ Arthritis _____ Anemia _____
Any other relevant family history? _____
What is your ethnic heritage? _____
Were you adopted? _____

CHILDHOOD ILLNESSES (please check)

Chicken Pox _____ Measles _____ Mumps _____
German Measles _____ Rheumatic Fever _____ Scarlet Fever _____
Diphtheria _____

IMMUNIZATIONS

Polio _____ Pertussis _____ Tetanus shot: when? _____
Diphtheria _____ Measles/Mumps/Rubella _____ Travel Related: _____

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations or surgeries, X-rays, CAT scans, MRI, EEG, EKG's have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

ALLERGIES / SENSITIVITIES

Are you hypersensitive or allergic to…

Any drugs? _____ Any foods? _____
Any thing environmental or chemicals? _____

CURRENT MEDICATIONS

Do you take or use? (please circle)

Laxatives _____ Pain relievers _____ Antacids _____
Cortisone _____ Appetite suppressants _____ Antibiotics _____
Tranquilizers/Sleeping pills _ Thyroid medication _____ Birth control pills/ Hormones _____

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_____lbs. Weight 1 year ago_____lbs.

Max Weight_____lbs. When?_____ Min Adult Weight_____lbs. When? _____

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

REVIEW OF SYSTEMS

Put a "C" next to any of the following conditions you currently have, and a "P" next to those conditions you have had in the past or are a significant part of your medical history.

LIFESTYLE

_____Alcohol, How much? How often? _____

_____Marijuana

_____Recreational Drugs

_____Treated for drug dependence

_____Stress

_____History of Smoking

_____How many packs per day?

_____How many years?

_____Occupational Hazards_____

_____Any major traumas (please explain)

MENTAL/ EMOTIONAL

_____Treated for emotional problems

_____Mood swings

_____Considered/attempted suicide

_____Poor Concentration

_____Depression

_____Anxiety or nervousness

_____Tension/stress

_____Memory Problems

SLEEP

How many hours do you sleep per night? _____

Do you wake rested? _____

Do you wake in the middle of the night? _____

If so, can you fall back to sleep easily? _____

Do you have trouble falling asleep? _____

Do you remember your dreams? _____

Do you have nightmares? _____

What position do you sleep in? _____

ENDOCRINE

_____Thyroid problems
_____Hypoglycemia
_____Excessive thirst
_____Fatigue
_____Previous diagnosis of endocrine problem?
If yes, what?_____
_____Heat or cold intolerance
_____Diabetes
_____Excessive hunger
_____Easy weight gain
_____Hair loss

IMMUNE

_____Chronic fatigue
_____Chronically swollen glands
_____Reaction to vaccines/immunizations
_____Chronic infections
_____Slow wound healing
_____Night Sweats

SKIN

_____Rashes
_____Acne/boils
_____Color change
_____Lumps/growths
_____Eczema, Hives
_____Itching
_____Changes in Hair/Nails
_____Skin Cancer? What type_____

HEAD

_____Headaches? Where?_____
_____Migraines
_____Head injury
_____Jaw/ TMJ problems

EYES

_____Spots in eyes/ Floaters
_____Impaired vision
_____Blurriness
_____Color blindness
_____Double vision
_____Glasses or contacts
_____Tearing or dryness
_____Itchy eyes
_____Red eyes
_____Eye strain or pain
_____Cataracts
_____Glaucoma

EARS

_____Impaired hearing
_____Earaches
_____Ringing in the ears/ Tinnitus
_____Dizziness or vertigo

NOSE AND SINUSES

_____Frequent colds
_____Stuffiness
_____Sinus problems
_____Congestion
_____Nose bleeds
_____Hayfever
_____Loss of smell
_____Post-nasal drip

MOUTH AND THROAT

_____Frequent sore throat
_____Teeth grinding
_____Gum problems
_____Dental cavities
_____Copious saliva
_____Sore tongue/lips
_____Hoarseness
_____Jaw clicks

NECK

_____Lumps
_____Goiter
_____Swollen glands
_____Pain or stiffness

RESPIRATORY

_____Cough
_____Spitting up blood
_____Asthma
_____Pneumonia
_____Emphysema
_____Pain on breathing
_____Positive TB test ever?
_____Shortness of breath at night
_____Sputum
_____Wheezing
_____Bronchitis
_____Pleurisy
_____Difficulty breathing
_____Shortness of breath
_____Shortness of breath lying down

CARDIOVASCULAR

_____Heart disease
_____High/Low blood pressure (circle which one)
_____Rheumatic Fever
_____Blood clots
_____Phlebitis
_____Angina
_____Swelling in ankles
_____Palpitations/Fluttering
_____Murmurs
_____Fainting
_____High Cholesterol
_____Chest Pain

Have you ever been diagnosed with a heart problem? Yes No If so, what?_____

_____

GASTROINTESTINAL/DIGESTION

_____Trouble swallowing
_____Reflux
_____Heart burn
_____Nausea
_____Vomiting/Vomiting blood
_____Change in appetite?
_____Change in thirst?
_____Belching
_____Gas and/or bloating
_____Ulcer
_____Abdominal pain or cramps? Upper or lower abdomen?
_____Constipation
_____Diarrhea
_____Blood, Mucus or undigested food in stool
_____Bowels move how often?_____
_____Is this a change?
_____Black/very dark stools
_____Hemorrhoids
_____Colon polyps
_____Gallbladder disease
_____Jaundice
_____Liver disease

URINARY

_____Pain on urination
_____Increased frequency
_____Urgency/inability to hold urine
_____Frequent Infections? Bladder or Kidney?
_____Frequency at night? How often?_____
_____Kidney stones

NEUROLOGIC

_____Seizures
_____Muscle weakness
_____Tremors
_____Paralysis
_____Fainting
_____Numbness or Tingling
_____Loss of memory
_____Difficulty Concentrating

MUSCULOSKELETAL

_____Joint pain or stiffness
_____Broken bones
_____Muscle spasms or cramps
_____Arthritis
_____Weakness

BLOOD/PERIPHERAL VASCULAR

_____Easy bleeding or bruising
_____Deep leg pain
_____Varicose veins
_____Anemia
_____Cold hands/feet
_____Thrombophlebitis

FEMALE REPRODUCTION/BREASTS

Age menses began_____Length of complete menstrual cycle (day 1 to next day 1) _____
# of days of menstrual flow_____Age of last menses (if menopausal) _____
Date of last annual exam/PAP (M/D/Y)_____

_____Irregular cycles
_____Bleeding between cycles
_____Cramps? If so, when?_____
_____Color of your blood?_____
_____Clotting? If so, what color?_____
_____Is your flow: scant/ normal/ excessive
_____PMS: breast tenderness, craving carbs, bloating, irritability
_____Sexually Transmitted Diseases: Which one(s)?_____
_____Vaginal discharge
_____Menopausal symptoms
_____Breast lumps
_____Breast pain/tenderness (other than PMS)
_____Nipple discharge

_____Abnormal PAP? When? _____
_____Cervical dysplasia
_____Endometriosis
_____Ovarian cysts
_____Uterine fibroids
_____Sexually active
_____Painful Intercourse
_____Sexual difficulties
_____Birth Control: type _____
_____Difficulty conceiving

Number of pregnancies_____
Number of miscarriages_____
Do you do self breast exams?_____
How often?_____
Have you had a hysterectomy? Yes No
If yes, how old were you?_____

Number of live births _____
Number of abortions _____

MALE REPRODUCTION

_____Hernias
_____Testicular Masses
_____Testicular Pain
_____Prostate problems or disease
_____Birth Control? What type?_____
_____Sexually Transmitted Disease: Which one(s)?_____
_____Do you do self testicular exams? How often?_____

_____Discharge or sores
_____Difficulty starting or stopping urination
_____Impotence
_____Premature ejaculation

EATING HABITS

Please circle:

Yes no	Dairy products such as milk, yogurt, cheese, etc.
Yes no	Red meat such as beef, buffalo, venison, lamb, pork (circle which ones)
Yes no	Fish or fowl such as tuna, chicken, turkey (circle which ones)
Yes no	Eggs (free range or caged – please circle)
Yes no	Commercially canned food
Yes no	Fruit or vegetable juice
Yes no	Refined cereals or products made with flour – pasta, bread etc.
Yes no	Vegetables
Yes no	Fruit
Yes no	Whole grains such as brown rice, millet, oats

How often you consume these items:

Sweetener (sugar, honey, maple syrup, etc.) _____

Pop, soft drinks _____

Pastries, donuts, cookies, cake _____

Pasta and/or bread_ _____

Ice cream _____

Coffee_____

Tea, caffeinated (green or black) _____

Nutrisweet (including diet sodas) _____

Preserved meats (cold cuts/lunch meats, hot dogs, etc)_____

Do you sleep on a waterbed?_____ Do you use an electric blanket? _____

Do you drink filtered water, bottled water or from the tap? _____

Do you use anti-perspirant? _____ Deodorant? _____

What brand? _____

Please list any chemicals, metals, dusts or fumes you are or were repeatedly exposed to.

Please include dates of exposure: _____

_____

How often do you exercise, and how? _____

_____

Names and ages of your children _____

_____

Do you have any pets? _____

What is your blood type? _____

DIET DIARY

Please list everything you eat or drink for three full, consecutive days. Please note how you feel on these days, if symptoms get better or worse etc.

	Day One	Day Two	Day Three
Breakfast			
Lunch			
Dinner			

Are you willing to change your lifestyle habits to improve your health? Yes No

What are your goals pertaining to your health, both short and long term?