back to balance
HOLISTIC FAMILY HEALTHCARE

HILARY BACK, ND, LAc
Naturopathic Doctor
Licensed Acupuncturist

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 provider 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 us, hopefully before the first visit.

Thank you for putting your time into this preparation. Please remember to bring the new patient paperwork with you to your appointment on at .
You can also email the paperwork to support@backtobalancedoc.com. 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 $150 charge for missed first appointments that are not canceled 24 hours in advance.**

I look forward to meeting you.

Sincerely,

Hilary Back, ND, LAc

20 North 4th Street, Carbondale, CO 81623
office 970.963.6500 | fax 970.963.2950
support@backtobalancedoc.com | www.backtobalancedoc.com

Education and Fee Schedule

Hilary Back, ND, LAc., obtained her degrees from National College of Naturopathic Medicine (6/00), currently National University of Natural Medicine. 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 CoAND. She is registered / licensed in the state of Colorado as a naturopathic doctor, registration # 0003 and as an acupuncturist, license # 637. Dr. Back has been trained to treat with acupuncture and Chinese herbs as well as all naturopathic modalities.

Fee Schedule: an Initial Consult is 1 ½ - 2 hours at a rate of $200 per hour, therefore the rate is $300 - $400. All prices are based on the length of time for the visit. If the visit exceeds expected time you will be charged accordingly. Follow up appointments are: ½ hour for $100, ¾ hour for $150, and a one hour follow up for $200. Follow up acupuncture visits are based on time and are generally $100. Follow up acupuncture visits with naturopathic manipulation are $150. Cosmetic Acupuncture is $200 per session.

Consultation phone calls will be charged at $50 per fifteen minutes. Excessive time spent reading letters, e-mails, faxes and responding to them will be charged at $50 per fifteen 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.

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

Signature Date

BACK TO BALANCE
20 N 4th Street, Carbondale, CO 81623
970-963-6500

DISCLOSURES AND INFORMED CONSENT

WELCOME. We are honored to be a part of your journey to better health.

SERVICES: Naturopathic Medicine and Acupuncture are branches of the healing arts distinct from other branches. Our services include the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, physical agents, acupuncture, and other therapies and modalities designed to support the body's natural healing processes. Our Naturopathic Doctors (ND) are registered under the Colorado Naturopathic Doctor Act. They are not Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Chiropractic (DC), or Doctors of Nursing (DNP) who are licensed under separate practice acts. As Naturopathic Doctors in Colorado, we do not prescribe, dispense, administer, or inject controlled substances (including general or spinal anesthetics) or practice medicine (including performing surgery, obstetrics, or administering ionizing radiation therapy). The only adjustments, manipulations, and mobilizations we perform are naturopathic manual therapies. We cannot recommend against a course of care recommended or prescribed by a licensed provider in another branch of the healing arts. We recommend that our pediatric patients follow the CDC immunization schedule (copy attached) and have a relationship with a licensed pediatric health care provider. We offer Acupuncture and Naturopathic Medicine to patients of all ages.

ALTERNATIVES AND COLLABORATION: Alternatives to Naturopathic Medicine and Acupuncture include declining such care and consulting with others such as an MD, DO, DC, or DNP. Naturopathic Medicine and Acupuncture are not a substitute for other types of health care and we encourage you to seek second opinions, have a relationship with an MD or DO, to communicate with all your providers about the care recommended in our office, and to authorize us to attempt to collaborate with your other providers. If applicable, please identify the provider with whom we should attempt to collaborate:

Provider: Phone:

RISKS: Naturopathic Medicine and Acupuncture are generally considered safe but may involve some risks including, without limit: all of the risks disclosed with any preparations or medicines; allergic reaction; infection; pain or discomfort; weakness, fainting, or nausea; skin irritation, discoloration, or scarring; aggravation of symptoms; mood changes; and rarely, neurological injury. There have also been instances reported of spontaneous miscarriage, and pnueomothorax. Naturopathic Medicine may adversely interact with specific drugs and may be inappropriate during pregnancy. Naturopathic manual therapies involve risks including, without limit, fractures, disc injuries, dislocations, and sprains. Additionally, hidden conditions may exist that are not detectable through examination. This may include spinal tumors, weak or occluded arteries, and aneurysms. Accordingly, some people are at risk for stroke or vascular injuries as a result of manual therapies.

EMERGENCIES: If you are having a medical emergency, do not wait to seek care. Call 911.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Our fee schedule is attached. Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. You may terminate care at any time. Prorated fees for unused, prepaid services will be refunded; however, no refunds are available for product purchases.

RIGHTS: You are entitled to receive information about your provider's credentials (attached), the methods of therapy, the techniques used, and the duration of therapy, if known. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of DORA. We are regulated by DORA (1560 Broadway, #1350, Denver, CO 80202 303-894-7800) and comply with CDPHE rules and regulations, including needle cleaning and sterilization and office sanitation.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!
I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

Patient or Person with Authority to Consent **Date**

BACK TO BALANCE
20 N 4th Street, Carbondale, CO 81623
www.backtobalancedoc.com
NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT
This notice describes how your health information may be used and disclosed. Please Review it carefully.

Your Rights
You have certain rights with respect to your health information, subject to legal limitations, including:
- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request, and we may say "no." If, however, you pay for a service or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with, and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: Privacy Officer, 20 N 4th Street, Carbondale, CO 81623, 970-963-6500, or help@backtobalancedoc.com; or U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

Your Choices
- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures
We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.

We are also allowed or required to share your information in other ways, such as:
- Providing you with information related to your health;
- Contacting you regarding appointments, treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence);
- Providing information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when: Information is relevant to the individual's involvement with your care;

• Notification of your location, general condition or death;
• To assist in your heath care (pick-up prescriptions or documents, follow-up care instructions etc.).

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

Our Responsibilities
We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

Changes to the Terms of this Notice
We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This Notice is effective September 23, 2013.

For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.*

Patient Acknowledgement

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

Signature of Patient/Legal Guardian **Date**

Print Patient Name (required) **Print Legal Guardian Name (if necessary)**

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

_____ _____

***Signature* of Practice Representative** **Date**

PERSONAL INFORMATION

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 check and indicate which relative{s})?

- ☐ Cancer
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Asthma/Hayfever/Hives
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Stroke
- ☐ Arthritis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Anemia

Any other relevant family history?

What is your ethnic heritage?

Were you adopted?

CHILDHOOD ILLNESSES (please check)

- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Measles
- ☐ Scarlet Fever
- ☐ Mumps
- ☐ Diphtheria
- ☐ German Measles

IMMUNIZATIONS

- [ ] Polio
- [ ] Tetanus shot: when?
- [ ] Measles/Mumps/Rubella
- [ ] Pertussis
- [ ] Diphtheria
- [ ] 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:

ALLERGIES / SENSITIVITIES

Are you hypersensitive or allergic to

Any drugs?

Any foods?

Anything environmental or chemicals?

CURRENT MEDICATIONS

Do you take or use? (please check)

- [ ] Laxatives
- [ ] Cortisone
- [ ] Tranquilizers/Sleeping pills
- [ ] Pain relievers
- [ ] Appetite suppressants
- [ ] Thyroid medication
- [ ] Antacids
- [ ] Antibiotics
- [ ] 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

Check any of the following conditions you currently have and any conditions you've had in the past that you feel are significant parts of your medical history.

LIFESTYLE

- [ ] Alcohol, How much? How often?
- [ ] Marijuana
- [ ] Recreational Drugs
- [ ] Treated for drug dependence
- [ ] Stress
- [ ] History of Smoking, 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

Below answer each question in the text box.

How many hours do you sleep per night?

Do you wake rested?

Do you wake in the middle of the night?

If yes, can you fall back to sleep easily?

Do you have trouble falling asleep?

Do you remember your dreams?

What position do you sleep in?

ENDOCRINE

- [ ] 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
- [ ] 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?
- [ ] Sputum
- [ ] Wheezing
- [ ] Bronchitis
- [ ] Pleurisy
- [ ] Difficulty breathing
- [ ] Shortness of breath

☐ Shortness of breath lying down

☐ Shortness of breath at night

CARDIOVASCULAR

☐ Heart disease

☐ High/low blood pressure

☐ 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? If so, what?

GASTROINTESTINAL/DIGESTION

☐ Trouble swallowing

☐ Reflux

☐ Heartburn

☐ 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?

- [ ] 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
- [ ] Sciatica

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 day 1)

# of days of menstrual flow

Age of last menses (if menopausal)

Date of last menses

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
☐ 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
☐ Sexually Transmitted Disease: Which one(s)?
☐ Painful Intercourse
☐ Sexual difficulties
☐ Birth Control: type
☐ Difficulty conceiving

Number of pregnancies Number of live births

Number of miscarriages Number of abortions

Do you do self-exams of your breasts? ⊙Yes ○No

How often?

Have you had a hysterectomy? ○Yes ○No

If yes, how old were you?

MALE REPRODUCTION

☐ Hernias
☐ Testicular Masses
☐ Testicular Pain
☐ Prostate problems or disease
☐ Impotence
☐ Sexually active
☐ Sexually Transmitted Disease:
Which one(s)?

☐ Discharge or sores
☐ Difficulty starting or stopping urination
☐ Premature ejaculation
☐ Birth Control?
What type?
☐ Do you do self testicular exams?
How often?

EATING HABITS

Please click:

⊙ Yes ○ no Dairy products such as milk, yogurt, cheese, etc.
⊙ Yes ○ no Red meat such as beef, buffalo, venison, lamb, pork
⊙ Yes ○ no Fish or fowl such as tuna, chicken, turkey
⊙ Yes ○ no Eggs
⊙ 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?

Anything else you would like to tell me?