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. 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 $300 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

Hilary Back, ND, LAc., obtained her degrees from National College of Naturopathic Medicine (2000), 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 (2000). 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

- Initial Naturopathic/Acupuncture Consult: $600
- Follow up appointments: $300
- Follow up Acupuncture: $150 - $300
- Cosmetic Acupuncture: $300
- Initial Naturopathic Manipulation: $150
- Follow up Naturopathic Manipulation: $75

If any visit exceeds the allocated time, you will be charged at the rate of $300 per hour.

Consultation phone calls will be charged at $75 per fifteen minutes. Excessive time spent reading letters, e-mails, faxes and responding to them will be charged at $75 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
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 Legal Guardian Name (if necessary) Print Patient Name (required)

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

_____ _____
Signature of Practice Representative Date

PERSONAL INFORMATION

Name _____ Date of First Visit_____

Parent/Guardian Name if you are a minor:_____

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_____

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? 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. _____

Referred by? _____

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

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

- ☐ 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 (Rubella)		

IMMUNIZATIONS (please check)

☐	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?_____

Anything environmental or chemicals? _____

CURRENT MEDICATIONS

Do you take or use? (please check)

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

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

Please check any of the following conditions you currently have or have had in the past that you feel are a significant part of your medical history.

LIFESTYLE

☐	Alcohol, how much?	☐	History of Smoking
☐	-How often?	☐	-How many packs per day?
☐	Marijuana	☐	-How many years?
☐	Recreational Drugs	☐	Occupational Hazards
☐		☐	Stress
☐	Any major traumas? (please explain)		
☐	_____		

MENTAL/ EMOTIONAL

☐	Treated for emotional problems	☐	Depression
☐	Mood swings	☐	Anxiety or nervousness
☐	Considered/attempted suicide	☐	Tension/stress
☐	Poor Concentration	☐	Memory Problems

SLEEP

☐	How many hours do you sleep per night?	☐	Do you have trouble falling asleep?
☐	Do you wake rested?	☐	Do you remember your dreams?
☐	Do you wake in the middle of the night?	☐	Do you have nightmares?
☐	If so, can you fall back to sleep easily? _____	☐	What position do you sleep in? _____

ENDOCRINE

☐	Thyroid problems	☐	Heat or cold intolerance
☐	Hypoglycemia	☐	Diabetes
☐	Excessive thirst	☐	Excessive hunger
☐	Fatigue	☐	Easy weight gain
☐	Previous diagnosis of endocrine problem? If yes, what?_____	☐	Hair loss

IMMUNE

☐	Chronic fatigue	☐	Chronic infections
☐	Chronically swollen glands	☐	Slow wound healing
☐	Reaction to vaccines/immunizations	☐	Night Sweats

SKIN

☐	Rashes	☐	Eczema, Hives
☐	Acne/boils	☐	Itching
☐	Color change	☐	Changes in Hair/Nails
☐	Lumps/growths	☐	Skin Cancer? What type_____

HEAD

☐	Headaches? Where?_____	☐	Head injury
☐	Migraines	☐	Jaw/ TMJ problems

EYES

☐	Spots in eyes/ Floaters	☐	Tearing or dryness
☐	Impaired vision	☐	Itchy eyes
☐	Blurriness	☐	Red eyes
☐	Color blindness	☐	Eye strain or pain
☐	Double vision	☐	Cataracts
☐	Glasses or contacts	☐	Glaucoma

EARS

☐	Impaired hearing	☐	Ringing in the ears/ Tinnitus
☐	Earaches	☐	Dizziness or vertigo

NOSE AND SINUSES

☐	Frequent colds	☐	Nose bleeds
☐	Stuffiness	☐	Hayfever
☐	Sinus problems	☐	Loss of smell
☐	Congestion	☐	Post-nasal drip

MOUTH AND THROAT

☐	Frequent sore throat	☐	Copious saliva
☐	Teeth grinding	☐	Sore tongue/lips
☐	Gum problems	☐	Hoarseness
☐	Dental cavities	☐	Jaw clicks

NECK

☐	Lumps	☐	Swollen glands
☐	Goiter	☐	Pain or stiffness

RESPIRATORY

☐	Cough	☐	Sputum
☐	Spitting up blood	☐	Wheezing
☐	Asthma	☐	Bronchitis
☐	Pneumonia	☐	Pleurisy
☐	Emphysema	☐	Difficulty breathing
☐	Pain on breathing	☐	Shortness of breath
☐	Positive TB test ever?	☐	Shortness of breath lying down
		☐	Shortness of breath at night

CARDIOVASCULAR

☐	Heart disease	☐	Swelling in ankles
☐	High/low blood pressure	☐	Palpitations/Fluttering
☐	Rheumatic Fever	☐	Murmurs
☐	Blood clots	☐	Fainting
☐	Phlebitis	☐	High Cholesterol
☐	Angina	☐	Chest Pain
☐	Have you ever been diagnosed with a heart problem? If so, what?		

GASTROINTESTINAL/DIGESTION

☐	Trouble swallowing	☐	Constipation
☐	Reflux	☐	Diarrhea
☐	Heart burn	☐	Blood, Mucus or undigested food in stool
☐	Nausea	☐	Bowels move how often?_____
☐	Vomiting/Vomiting blood	☐	Is this a change?
☐	Change in appetite?	☐	Black/very dark stools
☐	Change in thirst?	☐	Hemorrhoids
☐	Belching	☐	Colon polyps
☐	Gas and/or bloating	☐	Gallbladder disease
☐	Ulcer	☐	Jaundice
☐	Abdominal pain or cramps? Upper or lower abdomen? _____	☐	Liver disease

URINARY

☐	Pain on urination	☐	Frequent Infections? Bladder or Kidney?
☐	Increased frequency	☐	Frequency at night? How often?_____
☐	Urgency/inability to hold urine	☐	Kidney stones

NEUROLOGIC

☐	Seizures	☐	Fainting
☐	Muscle weakness	☐	Numbness or Tingling
☐	Tremors	☐	Loss of memory
☐	Paralysis	☐	Difficulty Concentrating

MUSCULOSKELETAL

☐	Joint pain or stiffness	☐	Arthritis
☐	Broken bones	☐	Weakness
☐	Muscle spasms or cramps	☐	Sciatica

BLOOD/PERIPHERAL VASCULAR

What is your blood type?_____

☐	Easy bleeding or bruising	☐	Anemia
☐	Deep leg pain	☐	Cold hands/feet
☐	Varicose veins	☐	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	☐	Abnormal PAP? When?
☐	Bleeding between cycles	☐	Cervical dysplasia
☐	Cramps? If so, when?_____	☐	Endometriosis
☐	Color of your blood?_____	☐	Ovarian cysts
☐	Clotting? If so, what color?_____	☐	Uterine fibroids
☐	Is your flow: scant/ normal/ excessive	☐	Sexually active
☐	PMS: breast tenderness, craving carbs, bloating, irritability	☐	Sexually Transmitted Disease: Which one(s)?_____
☐	Vaginal discharge	☐	Painful Intercourse
☐	Menopausal symptoms	☐	Sexual difficulties
☐	Breast lumps	☐	Birth Control: type_____
☐	Breast pain/tenderness (other than PMS)	☐	Difficulty conceiving
☐	Nipple discharge		

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	☐	Discharge or sores
☐	Testicular Masses	☐	Difficulty starting or stopping urination
☐	Testicular Pain	☐	Impotence
☐	Prostate problems or disease	☐	Premature ejaculation
☐	Sexually active	☐	Birth Control:type _____
☐	Sexually Transmitted Disease: Which one(s)?_____	☐	Do you do self testicular exams? How often? _____

EATING HABITS

Please check:

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? _____

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 1	DAY 2	DAY 3
Breakfast			
Lunch			
Dinner			

WELLNESS GOALS

How long have you suffered with chief your problems?_____

Any other complaints:_____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation

☐ Sleep: Falling asleep or staying asleep

☐ Sense of Well Being

☐ Energy

What have you tried doing to resolve this problem that did not work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When a problem is at its worst, how much older does this make you feel? _____

_____

Do you know how this problem may have started?_____

_____

What effect does this have on your body functions?_____

_____

Are you here visiting us to:

- ☐ Resolve my immediate problem
- ☐ Life style program for optimized living
- ☐ Other: _____

How have you taken care of your health in the past? Please check

☐	Medications	☐	Holistic
☐	Routine medical	☐	Vitamins
☐	Exercise	☐	Chiropractic
☐	Diet and Nutrition	☐	Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please check.

☐	Jobs	☐	Freedom
☐	Kids	☐	Future abilities
☐	Marriage	☐	Finances
☐	Sleep	☐	Time

Are there any health conditions you are afraid this might turn into?

☐	Diminished future abilities	☐	Surgery
☐	Stress	☐	Arthritis
☐	Weight gain	☐	Cancer
☐	Heart Disease	☐	Diabetes
☐	Depression	☐	Other:_____ _

Where do you picture yourself in the next 3-5 years if this problem is not taken care of? Please be specific.

What would be different or better without this problem? Please check.

☐	Diminished stress	☐	Sleep
☐	More energy	☐	Work
☐	Self-esteem	☐	Outlook
☐	Confidence	☐	Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list.)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor in helping you?

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

Anything else you would like to tell me?

Thank You!