HILL COUNTRY
Integrative Medicine

General Information: **Today's date:**_____

Name:_____ DOB:_____ Age: _____

Address:_____ email:_____

City: _____ State: _____

cell phone: _____ work/home phone:_____

Allergies: *medications/supplements or food reactions:*

_____

_____

Complaints/Concerns:

What do you hope to achieve at your visit today?

_____

_____

When was the last time you felt well?_____

Did something trigger your change in health?_____

What makes you feel worse? _____

What makes you feel better? _____

Medical History: Do you have any of the following conditions or experienced any of the following symptoms in the past 6 months? *Check appropriate box*

Musculoskeletal/Skin	***Eyes/Ears/Throat/Respiratory Diseases***	***Endocrine/Autoimmune/Cancer***
❑ joint pains	❑ asthma	❑ Cancer(type)_____
❑ muscle pain	❑ Ear fullness/pain	❑ fatigue
❑ muscle cramps	❑ ringing of ears	❑ Type1 diabetes
❑ joint stiffness	❑ hearing loss	❑ Type 2 diabetes
❑ joint redness	❑ chronic sinusitis	❑ hypoglycemia (low blood sugar)
❑ skin rashes	❑ eye problems	❑ cold hands/feet
❑ acne	❑ distorted smell	❑ heat intolerance
❑ athlete's foot	❑ swallowing problems.	❑ metabolic syndrome
❑ bruising	❑ sore throat	❑ low thyroid
❑ hair loss	❑ change in voice	❑ overactive thyroid
❑ brittle nails	❑ bronchitis	❑ Lupus SLE
❑ shingles	❑ emphysema	❑ Immune Deficiency
❑ vitiligo	❑ pneumonia	❑ polycystic ovary syndrome
❑ hives	❑ tuberculosis	❑ PMS
❑ eczema	❑ sleep apnea	❑ infertility
❑ itching	❑ snoring	❑ weight problems
❑ tendonitis	❑ chronic cough	❑ enlarged lymph nodes
❑ osteoarthritis	❑ allergic rhinitis	❑ enlarged glands
❑ Rheumatoid arthritis	❑ seasonal allergies	❑ exposure to pesticides/herbicides
❑ Herpes virus	❑ chemical allergies	❑ exposure to heavy metals or industrial chemicals
		❑ Exposure to mold (prior or current)

Mood	***Neurologic:***	***Digestive:***
❑ Depression ❑ irritable ❑ rage/anger ❑ Anxiety ❑ Bipolar ❑ Schizophrenia ❑ ADD/ADHD ❑ suicidal thoughts ❑ phobias ❑ Insomnia ❑ Hormone triggered	❑ tension headache ❑ dizziness ❑ fainting ❑ tremor ❑ hallucinations ❑ migraines ❑ seizure ❑ dementia ❑ memory issues ❑ Multiple Sclerosis ❑ Autism ❑ restless leg syndrome	❑ Acid reflux/heartburn ❑ Constipation ❑ Diarrhea ❑ Irritable bowel syndrome ❑ Colon polyps ❑ Colon cancer ❑ Hemorrhoids ❑ Ulcers ❑ Food sensitivities ❑ Inflammatory bowel disease ❑ gas/bloating excessive ❑ vomiting/nausea

Surgeries/Hospitalizations: *check appropriate box & fill in year if known and complications if any:*

- ❑ Appendectomy_____
- ❑ C/section(s)_____
- ❑ Bladder suspension_____
- ❑ Hysterectomy+/-ovaries?_____
- ❑ GallBladder_____
- ❑ Hernia_____
- ❑ Tonsillectomy/Adenoids_____
- ❑ Dental_____
- ❑ joint:_____when_____
- ❑ Heart (bypass) Surgery, Angioplasty,stent_____
- ❑ Heart Pacemaker _____
- ❑ other Hospitalizations_____
- ❑ broken bones_____

Any other problems you think we should know about?

_____
_____
_____

Primary Care Physician: _____
Any Specialist Physicians:_____

Gynecological History for Females:

Obstetric: *check box if yes and provide #*

❑ pregnancies_____	❑ Caesarean_____	❑ Vaginal_____
❑ Miscarriages_____	❑ Abortion_____	❑ Living Children____
❑ postpartum depression	❑ baby >8#_____	❑ breast feeding

Menstrual History for Females:

Age at 1st period_____ Menses every ____days period length?____days
pain? yes / no clotting? yes / no Is your period regular? yes / no
Date of last menstrual period_____
Sex drive issues? yes / no? Orgasm issues? yes / no?
Have you ever used birth control pills? yes / no?
Have you had or have an IUD? yes / no?
Other problems?_____

Men's History: *Circle any of the following:*
prostate problems decreased libido erection problems weak stream painful urination
testicle pain or lumps Other problems?_____

Birth History:
Were you born on time?_____or Premature?_____ Any Complications?_____

Dental History:
Name of Dentist:_____
Circle any of the following: fillings root canals implants gum disease

Medications:
Please include prescription, over the counter & supplements; write on the back or attach sheet:

Name	*Dose*	*Reason for Use*
(Example) Vitamin D	*5000 IU tablet 1x day*	*Low Vitamin D Level*

Have you used NSAIDs (Advil, aleve, naproxen, Mortrin,or ibuprofen) for prolonged periods?Y/N
Have you used Tylenol (acetaminophen) for prolonged periods? Y/N
Have you used acid blocking drugs for heartburn (Prilosec, Zantac, Tagamet, Nexium etc?) Y /N
Do you use antibiotics more than 3 times/ year? Y/N

Family History: *(family member)* *(family member)*

Breast Cancer		Eczema/Psoriasis	
Colon Cancer		Celiac Disease	
Prostate Cancer		Crohns colitis	
OtherCancer_____		Ulcerative colitis	
Heart Disease		Parkinsons	
Diabetes		Dementia	
Stroke		Psychiatric Disorder: (type)	
Obesity		ADHD	
Autoimmune Disease		Autism	
Thyroid Disease		Other Neurological Diseases	
Asthma			

Social History: *circle yes or no*

- Currently smoking? yes / no If yes, how many years?_____ Packs/day?_____
- Former smoker? yes / no If yes, how many years did you smoke?_____
- Alcohol use? yes / no *How many drinks per week?*_____
- Caffeine Intake: coffee?___*cup/day;* colas?___*cans/day;* diet colas?___can/day
- Current recreational drug use? yes / no If yes,type:_____
- Previous recreational drug use? yes / no If yes,type:_____
- Currently Exercising? yes / no If yes, list type and frequency (days/week):
  _____
- Do you enjoy exercise? yes / no
- Do you feel like you have an excessive amount of stress? yes / no If yes, explain
  _____
- Do you go to counseling? yes / no If yes, who?_____
- Are you willing to make significant health changes, including diet, exercise and stress management? yes / no

Relationship Status: *Please circle all that apply:*
single married divorced gay/lesbian/transgender long-term partnership widow
Any recent changes / stressors (e.g. death of loved one, separation, etc)? _____
_____
Employment/Occupation:_____
Are you satisfied in relationship? yes / no
Are satisfied in current employment? yes / no

Top Health Goal:

_____

_____

_____

Please bring form to your appointment

HILL COUNTRY
Integrative Medicine

Welcome to HCIM! It is our goal to provide you with a remarkable experience in health care. It is our mission to work as a team together in identifying modalities that will help you on your journey to optimal mental, spiritual, and physical health.

Practice Policies

Please read and initial each of the below items.

_____ Office Hours are 7:30 to 4:30 pm, Monday through Thursday, and Friday from 8am to 12 pm.

_____ New patient appointments require a deposit of 50% of the new patient consultation fee.

_____ HCIM does not participate with Medicare or any insurance company. All patients will be responsible for payment in full at the time of each appointment. I have received a copy of the practice fee schedule.

_____ I consent to receiving reminders for upcoming appointments by the following means: Email, phone / voicemail, and text message.

_____ We understand emergencies occur, but due to the amount of time given to your visit, we ask for 2 business days notification to cancel or reschedule appointments. The appointment fee will be charged for missed appointments or failure to provide 48 hours notice to cancel or reschedule. This includes telemedicine/phone appointments.

_____ We request 3 business days notice to process prescription refill requests.

_____ As Integrative and Holistic Medicine specialists, HCIM providers do not provide management of hospital patients, after-hours or weekend call. We recommend all of our patients maintain a relationship with a primary care physician as we cannot guarantee same-day acute visits and well examinations.

_____ A patient who has not been seen in the past three years will be considered inactive and will need to re-establish care as a new patient.

_____ Dr. Tara Boyd, ND, has completed Bastyr University's fully accredited 4-year Doctorate program, passed the NPLEX board exam, and is licensed in Washington and California. The state of Texas does not license Doctors of Naturopathic Medicine. In Texas, Dr. Boyd serves as a naturopathic wellness consultant and does not diagnose or treat disease.

I understand and agree to abide by the above policies.

Name (please print): _____

Signature: _____

Date: _____

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Dr. Christa O'Leary, D.O.
Dr. Tara Boyd, N.D.

Fee Schedule

New Patient Consultation (typically 60 minutes)	$350
Office visit up to 15 minutes	$75
Office visit up to 30 minutes	$150

email/phone consult per 15 minute interval	$75
Office visit up to 45 minutes	$225
Office visit up to 60 minutes	$300

Charity Lawson, M.S., CNS

Nutritionist Fee Schedule

New Client	$160
60 minute consultation	$150
45 minute consultation	$110

15 minute consultation	$35
30 minute consultation	$75
Menu planning	Varies

Visits in excess of 60 minutes are billed at the applicable provider rate in 15-minute intervals.

Fee schedule is subject to change.

HCIM accepts cash, check, credit cards and Health Savings Cards.

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103 Heritage Hills Drive, Fredericksburg, Texas 78624 | (830) 992-3042 | www.hillcountryintegrativemedicine.com

Deposit for New Patient Appointments

In consideration of time allotted to new patient appointments, a deposit of 50% of the new patient consultation fee is collected when the appointment is scheduled. This deposit will be applied to your bill upon checkout. We request 3 business days' notice to reschedule or cancel your appointment. If you cancel/reschedule your new patient visit **without** 3 business days notice or fail to show up on the day of your appointment, the deposit is not refunded.

Cancellation / Reschedule Policy For Follow-up Appointments

We have a 2 business day cancellation policy. A cancellation fee ($150 for doctor appointment, $75 for nutritionist appointment) may be charged if an appointment is canceled or rescheduled with less than 2 business days' notice. No-Shows and same day cancellations may result in a payment of 100% of the cost of your visit. If you are late for your appointment, your allotted time will be reduced accordingly.

I understand and agree to the above terms.

Patient Name: _____

Patient Signature: _____

Date: _____

I authorize Hill Country Integrative Medicine to charge my credit or debit card according to this policy.

Credit Card Number: _____

Expiration Date: ____ / ____ CVV Code: _____ Billing ZIP Code: _____

Name on Card _____

Signature: _____

Hill Country Integrative Medicine accepts cash, check, credit cards and HSA cards