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? _____

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_____

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

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

Any other problems you think we should know about?

_____

_____

Primary Care Physician: _____

Any Specialist Physicians:_____

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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

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Have you used NSAIDs (Advil, Aleve, naproxen, Motrin, 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

Ailment	**Family Member**	**Ailment**	**Family Member**
Breast Cancer		Eczema / Psoriasis	
Colon Cancer		Celiac Disease	
Prostate Cancer		Crohn's Colitis	
Other Cancer		Ulcerative Colitis	
Heart Disease		Parkinson's	
Diabetes		Dementia	
Stroke		ADHD	
Obesity		Autism	
Autoimmune Disease		Other Neurological Disease	
Thyroid Disease			
Asthma			

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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

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Practice Policies

Please read and initial each of the below items.

_____ Office Hours are 7:30 to 4:30 pm, Monday through Thursday.

_____ 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. A cancellation 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.

_____ HCIM offers telephone consultations. Patients utilizing telemedicine are asked to keep a credit/debit card on file.

_____ Patients may communicate directly with their provider via Patient Fusion. Depending on the circumstances and time spent responding to questions, providers may charge an email consultation fee.

I understand and agree to abide by the above policies.

Name (please print): _____

Signature: _____

Date: _____

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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.

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Effective January 2, 2024

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

New Patient Consultation (Typically 60 minutes)	$395.00	Email / Phone Consult per 15 minute interval	$85.00
Office Visit up to 15 minutes	$85.00	Office Visit up to 45 minutes	$260.00
Office Visit up to 30 minutes	$175.00	Office Visit up to 60 minutes	$350.00

Charity Lawson M.S., CNS
Nutritionist Fee Schedule

New Client	$195.00	15 minute consultation	$45.00
60 minute consultation	$180.00	30 minute consultation	$90.00
45 minute consultation	$135.00	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.