JoHannah Reilly ND, LAc
3400 Table Mesa Drive, Suite 203
Boulder, CO 80305
303-541-9600

Dear New Client:

I have found it extremely helpful to have you prepare some information before your first appointment, to ensure that the visit is as thorough as possible. Enclosed is a questionnaire, including a diet diary section. **Please complete the questionnaire and fill out the diet diary for any three days in a row between now and your scheduled visit.**

In addition, please write out a brief timeline of your own history, beginning with birth or early childhood. This history should include major illnesses, injuries, and/or hospitalizations, significant turning points or events in your life, any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. For women, please include events related to your reproductive system (first period, menopause, pregnancies, abortions, birth control, etc.) If you are filling this out for your child, please include any notable information about the pregnancy and nursing. If you are currently breast feeding your baby, please fill out the diet diary with **your** diet. Again, keep it brief and simple, we will go into detail as needed. Also, please bring a list of your current medications with dosages and bring with you any supplements and vitamins that you are currently taking.

Thank you for putting your time into this preparation. Please remember to bring it with you to your appointment. Experience has shown that the form, and the timeline in particular, greatly facilitates the visit. **In addition, please be sure to eat before your appointment.** Also, please refrain from wearing perfume, scented oils or strong smelling lotions for your visits to the office.

If you need to cancel this appointment, please call 48 hours in advance. **Barring emergencies, there will be a $200 charge for missed first appointments that are not cancelled 48 hours in advance.**

I look forward to meeting you.
Sincerely,

JoHannah Reilly ND

JoHannah Reilly ND, LAc

3400 Table Mesa Drive, Suite 203
Boulder, CO 80305
303-541-9600

***** CLIENT COPY *****

JoHannah Reilly ND, LAc is a Naturopathic Doctor and Licensed Acupucturist. She received her B.A. in Religious Studies from the University of Colorado and her B.S. in Human Biology from Kansas Neuman College. JoHannah specialized in the study of acupuncture and graduated as Doctor of Naturopathic Medicine from the National College of Naturopathic Medicine (currently known as National University of Natural Medicine) in Portland, Oregon in 1982. She was licensed in Montana as an acupuncturist and started her naturopathic practice in that same year. JoHannah received her Diplomate of Acupuncture from the National Commission for the Certification of Acupuncturists in 1989. Dr Reilly is licensed in Colorado as a Naturopathic Doctor and as a Licensed Acupuncturist. She practiced for eight years in Montana and has been practicing in Boulder, Colorado since 1990.

The cost for Treatment is:

• Initial visit:	3 Hour (Extensive) Adult Visit	$450.00
	2 Hour (Comprehensive) Adult or Child Visit	$300.00
	1 Hour (Acute) Adult Visit	$175.00
• Return visits:	Adult or Child Visit	$100.00
• Acupuncture/Detox:	Adult (4 treatments in one week)	$100.00

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

All expenses for supplements and herbs are in addition to the cost of the treatment.

24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS

JoHannah Reilly, N.D., LAc is in full compliance with all regulations and rules promulgated by the Department of Health. In order to ensure the safety of her clients she uses pre-sterilized disposable needles. As a patient you are entitled to receive information regarding your therapy, the treatment modalities used, and the duration of therapy if known. As a patient you may seek a second opinion from another healthcare professional, or you may terminate therapy at any time. The practices of naturopathic medicine and acupuncture are regulated by the Department of Regulatory Agencies. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the division of registration in the Department of Regulatory Agencies. The address and phone number for the complaints and investigation section is:
1560 Broadway, Suite 1350, Denver, CO 80202, Phone (303) 894-7855.

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

**Sign and Bring In Signature ______________________________ Date: ____________

JoHannah Reilly ND, LAc

3400 Table Mesa Drive, Suite 203
Boulder, CO 80305
303-541-9600

***** OFFICE COPY *****

JoHannah Reilly ND, LAc is a Naturopathic Doctor and Licensed Acupucturist. She received her B.A. in Religious Studies from the University of Colorado and her B.S. in Human Biology from Kansas Neuman College. JoHannah specialized in the study of acupuncture and graduated as Doctor of Naturopathic Medicine from the National College of Naturopathic Medicine (currently known as National University of Natural Medicine) in Portland, Oregon in 1982. She was licensed in Montana as an acupuncturist and started her naturopathic practice in that same year. JoHannah received her Diplomate of Acupuncture from the National Commission for the Certification of Acupuncturists in 1989. Dr Reilly is licensed in Colorado as a Naturopathic Doctor and as a Licensed Acupuncturist. She practiced for eight years in Montana and has been practicing in Boulder, Colorado since 1990.

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**Sign and Bring In Signature ____ Date: ________________

JoHannah Reilly ND, LAc
3400 Table Mesa Drive, Suite 203
Boulder, CO 80305
(303) 541-9600

DATE: ________________________________

EMAIL: ________________________________

NAME: ___________________________________ AGE______ DATE OF BIRTH________________

TIME OF BIRTH: _______________________ PLACE OF BIRTH: _________________________

IF CHILD, PARENT'S NAMES ____

ADDRESS _______________________________ CITY __________ STATE _____ ZIP __________

HOME PHONE ________________ WORK PHONE _______________ CELL _________________

OCCUPATION ____

REFERRED BY ______________________ YOUR DOCTOR'S NAME _________________________

- What is your main complaint or complaints?

- When did your symptoms begin?

- What precipitated or started the condition?

- Does anything make it better or worse? Such as time of day, heat or cold, season of the year, emotions, motion, or position? Is it worse on one side of the body?

- Can you think of any other complaints or problems, even though they may be insignificant to your or unrelated to your main complaint(s)?

- Please list SURGERIES and/or HOSPITALIZATIONS and their DATE:

- Do you have any allergies (medication, food, environmental)?

PLEASE √ THE APPROPRIATE BOX THAT CORRELATES WITH THE STATEMENT

C = Currently P = Past N = No/Never	**C**	**P**	**N**
Pain or abnormal sensation in chest (palpitations, tightness, etc.)?			
Shortness of breath?			
Aches or pain in the neck, middle back, or low back?			
Pain, numbness, or tingling in the arms or legs?			
History of injury or car accidents?			
History of concussion, or of hitting your head?			
Eating disorder such as bulimia, anorexia, or compulsive eating?			
Heartburn or nausea?			
Distress in upper abdomen or stomach?			
Diarrhea? ____________ Loose stools?			
Constipation? _________ Do you ever skip a day? **Yes/No**			
Any problems with gas or belching?			
Burning, pain, or urging with urination, or, if a male, with ejaculation?			
Any history of sexually transmitted disease, HPV, gonorrhea, herpes?			
Females – Do you have an irregular period? _____ Do you have painful cramps, heavy flow, clots? ____ How long is your cycle? _____ Days of flow? _______			
Females – Do you have PMS (breast tenderness, cravings, bloating, Irritability and/or night sweats) before your period? ___________________			

Females – Have you ever been pregnant? _____ Miscarriage? ____ Abortion? _____

Question	C	P	N
Do you ever get headaches? How often, where on your head? ___________________			
Have you ever been exposed to chemicals, pesticides, etc.?			
Have you ever served in the armed forces?			
Have you ever been abused physically, emotionally, sexually?			

Do you have any tattoos? **Yes / No** When did you get them? ____________

Have you ever had a blood transfusion? **Yes / No**

Do you remember your dreams **every** morning upon waking? **Yes / No**

Do you ever cry? **Yes / No** Do you want to be alone or get comfort? _________

Do you sleep well? **Yes / No** How many hours a night? ________ Naps? _____

What position do you sleep in at night? Back, stomach, sides? ___________________

Do you drool on your pillow at night? **Yes / No**

Do you bite your nails? **Yes / No**

Is it **extremely** important for you to be on time? **Yes / No**

What is your predominate emotion? Joy, anger, fear, sorrow, etc. ________________

What are your current prescriptive medications with dosages: ____

____

Do you have a regular exercise program? **Yes / No**

Please describe your program. (Days per week, type of exercise, intensity):

____

____

____

____

____

____

Eating Habits

(Please circle yes or no)

Yes / No Do you eat dairy products such as milk, yogurt, cheese, etc.
Yes / No Do you eat red meat: beef, venison, lamb, pork (circle if only one)
Yes / No Fish or Fowl such as tuna, chicken, turkey (circle if only one)
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
Yes / No Vegetables and legumes
Yes / No Fruit How many pieces a day? ______
Yes / No Whole grains such as brown rice, millet, oats
Yes / No Soy products such as tofu, soy milk, tempeh

Please mark how often you consume these items:

Spoon of sugar ________________ Cookies, cake ______________
Pop/soft drinks ________________ Ice cream ______________
Pastries, donuts ________________ Coffee ______________

Alcohol (list type and quantity) ____

Marijuana or other Recreational Drugs ______________________________________

Please List EVERYTHING You EAT and DRINK for Three Full Days*

	DAY 1	DAY 2	DAY 3
Breakfast			
Lunch			
Dinner			

*Children/Breastfeeding: If you are breastfeeding your baby, please fill out the diary with **your** diet. Keep it brief and simple, we can go into detail as needed.

Please list any vitamins, minerals, or supplements that you are taking: ____________________________________
____
____
____

Patient History-Timeline

In the space below, please write out a brief timeline in outline form, of your own history. Beginning with birth and early childhood, include any major illnesses, injuries, or hospitalizations, up to the present time.

Write where you lived, when you moved, and in general what your family life was like. Include significant turning points or major events in your life. Also include any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs.

For women, please include events related to your reproductive system such as first period, pregnancies, abortions, birth control, menopause, etc.

If you are filling this out for your child, please include notable information about the pregnancy and nursing.

Lifestyle Questions:

Yes / No Do you sleep on a waterbed?
Yes / No Do you use an electric blanket?
Yes / No Do you drink filtered water, bottled water, or from the tap? ______________________________
Yes / No Do you use anti-perspirant or deodorant? If yes, which one(s)______________________________
Yes / No Do you smoke/chew tobacco? If yes, how much a day? __________________________________
Yes / No Did you smoke/chew in the past? If yes, when and how much? ___________________________

Family History:

Yes / No Were you a foster child or adopted?

Please indicate below which ailments have affected your relatives.
List their current age or age at death.

	Age	Age at Death	Ailments / Cause of Death
Mother			
Father			
Brothers			
Sisters			
Mother's Mother			
Mother's Father			
Mother's Siblings			
Father's Mother			
Father's Father			
Father's Siblings			

List your children's name(s), age(s) and health:

List your partner's name and occupation:

Do you have pets? **Yes / No** What are your pets' names?

What are your long and short-term goals here?