Welcome!

In an effort to better serve you, below is a reminder checklist of things to prepare before your first visit:

* Fill out and sign all downloadable forms before your appointment.

* We want to remind you that we do not bill any business managers, insurance companies, etc.

* Payments, in the form of **check**, **cash or credit card (MC/V)**, are expected at the time services are rendered.

* There is paid parking in the building (sorry, we do not validate) and metered and restricted parking on surrounding streets. (Please be aware of street cleaning and other parking restrictions).

* Please allow approximately an hour and a half for your first visit and one hour for subsequent visits.

* Bring your new patient forms with you when you come in for your first visit: all new patient forms need to be complete before your first visit. Do not hesitate to discuss any questions you might have with us.

* Wear something very comfortable and loose fitting.

* Please do not come on an empty stomach. If you are hungry, please finish all full meals at least an hour before your treatment.

Again, welcome to Iyashi Wellness and we look forward to serving you!

Our address:

Iyashi Wellness

2001 S. Barrington Ave., Ste.219

Los Angeles, CA 90025

(424) 248-5576

Confidential Patient Record

Please print legibly

Patient Name: Date of Birth: / /

SS#: - - Sex: F / M DL # & State: Marital status: S / M / D / W

Home Address:

City: State: Zip:

Home Phone: Cell : Work:

Which phone number would you like us to call you at if we need to contact you?

Email address:

Occupation: Employer: Years Employed:

Would you like to receive a periodic e-newsletter from Iyashi Wellness about health and wellness? Y / N

Person responsible for this account?

Referred by:

May we contact them to thank them for their referral? Y / N

Emergency Contact: Relationship to Patient:

Emergency Contact phone number: cell: home:

Family Physician: Phone Number:

Patient's Medical Insurance Carrier: ID Number:

Phone Number: Insured Name: Relation:

Payment Information

Credit Card Number ____ (circle one) MC or Visa

Exp Date _________CCV code__________ Authorizing Signature ____________________________ Date _______________

Wellness Commitment

At our clinic, we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% ---------20%---------30%---------40%---------50%---------60%---------70%---------80%---------90%---------100%

Iyashi Wellness Policy

1. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Iyashi Wellness to release my personal medical information to me. **INITIAL: ______**

2. **CANCELLATION POLICY:** If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. *No shows and late cancellations less than 24 hours before appointment time will be charged at the full rate of the missed appointment.* **INITIAL: ______**

3. **SICK POLICY**: For the health and safety of our staff, patients and their families, we ask that you reschedule appointments when active infections are present (i.e. sore throat, fever, chills, vomiting, diarrhea). This will allow you to rest at home, and if a parent of a sick child, to help focus your energies in helping your child be comforted and cared for by you.

   We will however, provide herbal remedies to mitigate/lessen the severity of symptoms (both internal – and topical, if necessary) and speed up recovery via quick herbal consultation. **In lieu of a missed visit, we will do a phone consult** to support the immune response of the sick patient as well as to prevent latency that can often occur with infections (to learn more about latency, go to http://bit.ly/latentpathogen), which can lead to other chronic complications. **Please contact the office as soon as you know that you or your child is sick and unable to attend the visit, and we will convert the office visit to a phone herbal consultation.** (Herbs will be dispensed either through an online herbal pharmacy or made available for pick up at Iyashi Wellness.)

   INITIAL: ______

4. There is a service charge of $35.00 for every returned check from the bank. **INITIAL: ______**

5. In order to safe guard the quality of any herbs or supplements sold at Iyashi Wellness, no product returns will be granted, whether opened or not, custom or ready-made. **INITIAL: ______**

6. If you are under 18 years of age, please have your parent or legal guardian sign below. **INITIAL: ______**

7. Iyashi Wellness is required by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can also request a written copy. Please ask the office for more info.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

____

Signature Date

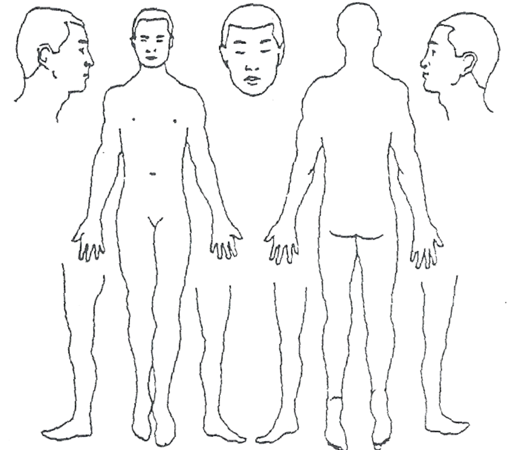
Name: ____ **Today's Date**: ____/____/____
(first) (middle) (last)

Date of Birth: ______/______/______ **Age**: ______ **Gender**: M / F **Marital status**: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. **Please tell us why you are coming in today and a brief history of your health concern. If more than one, list the top three concerns..**____

Please mark area(s) affected



- If pain, pain is: minimal moderate sharp stabbing dull aching shooting severe constant comes and goes
- What makes your condition worse? ______________________________
- What makes your condition better? ______________________________

2. **Have you been to any other professional for the problems you're coming into today** ? Yes No
   a. If yes, Who? ______________________________ MD, DC, DO, ND, PA, NP, Other
   b. What were the results?______________________________
   c. Were the results permanent? Yes No Don't know
3. **What health goals would you like met under Luriko's care?** ______________________________
4. **Are you as healthy today or healthier than you were 5 years ago**? Yes No Don't know
5. **Do you feel you will stay as healthy as you are today 5 years from now**? Yes No Don't know
   a. If yes, what strategies will you implement to get there? ______________________________
6. **How long has it been since you really felt good**? ______________________________
7. **When and where did you last receive health care**? ______________________________
   b. For what reason? ______________________________
8. **Please answer the following questions by circling the correct answer**

Do you have a tendency to faint?	Yes	No	Are you HIV positive?	Yes	No
Do you have a pacemaker?	Yes	No	(Women) Are you pregnant?	Yes	No
Do you bleed for a long time?	Yes	No	Have you ever had Hepatitis?	Yes	No

9. **Sexually Transmitted Disease**: Gonorrhea Syphilis HPV Chlamydia Herpes
10. **Height:** ________ **Weight:** Currently: ________ Past Maximum: ________ When? ______________

11. **Blood Pressure:** ________________________________ When was this reading taken?_____________________________

12. **Skin:** dry itchy moist/clammy burning changing moles or lumps (cysts/tumors) acne hair loss/thinning dry scalp/dandruff

13. **Bowels:** Number of movements a day:__________ If less than one a day, how many per week? __________

    You have: constipation diarrhea/loose stools bloody stools black stools white/light color stools mucus in stools hemorrhoids unusually foul smelling stools colon problems other:_________________________

14. **Urination:** How many times do you urinate a day? ___________ normal color (pale yellow) clear dark yellow reddish cloudy has odor burning painful difficult/weak urgent

15. **Sleep:** Number of hours of sleep a night: _________

    What time do you normally go to sleep? __________ What time do you normally wake up? ____________

    You have: difficulty falling asleep difficulty staying asleep dream disturbed sleep night sweats wake up to urinate: _____ times per night

16. **How was your health as a child?** (circle one) excellent / good / fair / poor.

    If fair or poor, why?____

17. **Hospitalizations, Surgeries, and Accidents – please include dates, reasons for use, and outcomes:**_______________

    ____

    ____

18. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies- please include dates, reasons for use:**_______________________

    ____

    ____

19. **Please list any medications and supplements you are currently taking (attach separate page if necessary):**

Drug/supplement name:	**dosage**	**How long have you been on it?**	**Prescribing Doctor's name**	**Why are you taking this medication?**

20. **Family History:**

	Self	Paternal	Maternal
Health (G=Good, P=Poor)	________	_________	_________
Cancer	________	_________	_________
Diabetes	________	_________	_________
Arthritis	________	_________	_________

Check those applicable:

Heart Disease	________	________	________
Hepatitis:________	________	________	________
High Blood Pressure	________	________	________
Epilepsy	________	________	________
Stroke	________	________	________
Mental Illness	________	________	________
Asthma/Hay fever/Hives	________	________	________
Kidney Disease	________	________	________
Thyroid Disorder	________	________	________
Autoimmune Disorder	________	________	________

Father: Age ______ Deceased

Cause of Death:______________________

Mother: Age ______ Deceased

Cause of Death:______________________

How many siblings do you have?

Sister(s) _________

Cause of Death:______________________

Brother(s)_________

Cause of Death:______________________

21. **Dental work**:
    a. Root canal? Yes No If yes, when and how many? ____
    b. Teeth extracted, including: Wisdom? Yes No If yes, when? ____
    c. Bridges in mouth? Yes No
    d. Fillings? Yes No
    e. Crowns? Yes No
    f. Braces? Yes No
    g. TMJ (jaw problems) Yes No

22. Your Birth Factors (NOT your child's):
    h. C-Section Yes No
    i. Premature Yes No
    j. Forceps Delivery Yes No
    k. Breach Delivery Yes No
    l. Bottle-Fed Yes No
    m. Breast-Fed Yes No
    n. Birth Trauma: (Describe)

    ____

    ____

23. **What is your ethnic heritage?** (eg.Irish, Chinese, etc.)____

24. Describe yourself, your personality and character traits:

____

____

Please continue to the next page

25. Do you have any of the following symptoms? If you do, whether *NOW* or *IN THE PAST*, *please mark "N" or "now" and "P" for "past" :*

N or P		N or P	**(KD)**
	fatigue		sore, cold weak knees
	feverish in the afternoon or hot flashes		low back pain
	heat sensations in the hands, feet, chest		urinary problems (frequent, difficult, etc.)
	dizziness		get up more than once a night to urinate
	(HT)		enlarged prostate
	mood swings		memory problems
	heart murmur		hair loss
	high blood pressure		ringing in ears: low pitch or high pitch?
	palpitations		night sweating
	sores on the tip of tongue		**(SP/ST)**
	anxiety / nervousness / fidgety / restless		slow healing wounds
	chest pain radiating to shoulder		TMJ / grinding teeth
	ankle swelling		shortness of breath (inhale or exhale)
	stutter		Low/no appetite
	(LU)		excess appetite; eating doesn't satiate hunger
	sweat easily, even with little exertion		abdominal bloating or gas after eating
	cough		feeling tired after eating
	sinus congestion / pressure		burning sensation after eating
	dry mouth, throat, nose or skin		Jittery/shaky, irritable or light-headed if miss a meal
	allergies / hay fever		bruise easily
	catch colds and flus easily		general feeling of heaviness in the body
	asthma		mental sluggishness/ forgetfulness/exhaustion
	frequent sore throats		prolapsed organs (previously diagnosed)
	chills alternating with fever		swollen hands / feet
	stiff neck / shoulders		bad breath
	difficult breathing		mouth sores (canker sores)
	(LV)		bleeding, swollen painful gums
	diarrhea alternating with constipation		heartburn / belching
	tight feeling in the chest		stomach pain / stomach ulcer
	bitter taste in the mouth		vomiting
	blood shot eyes / dry eyes		varicose veins
	anger easily		eczema/hives
	skin rashes		anemia
	headache – where on the head?:		constipation
	numbness of hands and feet		Hemorrhoids or anal itching
	muscle spasms, twitching, cramping		diarrhea
	seizure / convulsions		**Allergies/Sensitivities**
	see floating black spots		Animal hair/dander
	blurred vision		Chemicals:
	one-sided pain/discomfort		Dust, molds
	pain/tenderness in the ribs		Food:
	cold hands/feet		Grasses, weeds, pollen
	Neck and shoulder tension/pain		Medication:
			Others:

17. ***MEN Only***			
Please put a check mark by the symptoms that pertain to you.			
( )	Feeling of coldness or numbness in the external genitalia	( )	Low sex drive
( )	Pain or swelling of testicles	( )	Lack of sex drive
( )	Premature ejaculation	( )	Discharges
( )	Impotence / erectile dysfunction	( )	Painful/burning urination
( )	Prostate problem	Other:	

18. ***WOMEN Only***			
Please answer each question.			
A.	Are your currently pregnant now? Y N maybe	K.	Date of last period:
B.	No. of pregnancies:	L.	Date of last PAP smear test:
C.	No. of miscarriages:	M.	Age of first period:
D.	No. of abortions:	N.	Age of last period:
E.	Menstrual Cycle – 28 day cycle? Y / N If not, how many day?		
F.	Average number of days of flow:		
G.	Are you on birth control? Y / N		
H.	Describe a typical menstruation, with color, any pain or discomfort associated with it, and amount of flow. Example: Day 1 is heavy with cramping and dark blood, Day 2 is heavy w/o cramping but bright blood, Day 3 is normal flow, Day 4 becomes light with pinkish color, Day 5 finish		

Please check the appropriate responses.			
( )	menopausal symptoms	( )	vaginal discharge
( )	premenopausal symptoms	( )	nipple discharge
( )	PMS	( )	vaginal itching
( )	bleeding between cycles	( )	endometriosis
( )	low back pain	( )	fibroids
( )	Painful periods	( )	ovarian cysts / PCOS
( )	blood clots	( )	UTIs
( )	irregular cycle	( )	polyps
( )	breast lumps / tenderness	( )	pelvic inflammatory disease
( )	difficulty conceiving	**Operations:**	
( )	water retention	( )	Cervix
( )	missed periods	( )	Uterus
( )	food cravings:	( )	Ovaries
( )	fatigue w/periods	( )	others:
( )	headaches w/periods		

19. **LIFESTYLE**

a. How many full meals a day do you eat? ______ Do you snack in between meals? ______ If yes, how many? _____

b. Please describe your typical daily diet:

- Breakfast ____
- Lunch ____
- Dinner ____
- Snacks ____

c. What percent of your food do you prepare yourself? __________%

d. What times do you usually eat: breakfast: ________am; Lunch: _______pm; Snacks: _________; Dinner:______pm

e. Are you satisfied with your diet? Y / N Do you diet often? Y / N

f. Do you have any dietary restrictions (e.g. vegetarian, low salt)? Y / N

- Please specify:____

g. Any nutritional concerns you would like to discuss? ____

h. Please indicate the use and frequency of the following:

	Yes	No	Daily Amount		Yes	No	Daily Amount
Coffee/Black tea			_______	Tobacco			_______
Recreational Drugs			_______	Alcohol			_______
Water intake			_______	Soda pop			_______

i. Exercise routine: ____

j. Spiritual practice: ____

k. Occupation: ______________________________ Hours working/week: ____________________

l. Do you enjoy work? Y / N Why/Why not? ____

____

m. Does your *work* environment have a: supportive unsupportive effect on your health?

n. Are you regularly exposed to: smoke chemicals/chemical fumes other toxins?

o. Does your *home* environment have a: supportive unsupportive effect on your health?

p. How is your emotional health? (circle one) good fair poor varies

q. Are you currently involved in psychotherapy? Y / N

r. Do you feel you have a good support network? Y / N

s. Have you experienced any major emotional or physical traumas? Y / N

Explain: ____

t. Daily T.V. viewing habits: ____________________ Daily Reading habits: ____________________

u. Interests and hobbies:____

____

v. Lastly, Is there anything else we you'd like to share with us?______________________________

____

Thank you!

Luriko P. Ozeki, L.Ac.
Iyashi Wellness
2001 S. Barrington Ave., Ste 219, Los Angeles, CA 90025

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:____ Date of Birth:__________________

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses are disclosures that will be made only with my written authorization and that may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complaint to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice current notice of privacy practices on request.

Signature:____ Date:_______________

Relationship to patient (if signed by a personal representative of patient):__________________