



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:

**The Gardens**

**2001 S. Barrington Ave., Ste.111**

**Los Angeles, CA 90025**

**(310) 770-9560**

## Confidential Patient Record

Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: F / M

Driver's license # & State: \_\_\_\_\_ Marital status: S M D W

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile number: \_\_\_\_\_ Email address: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Company Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work phone number: \_\_\_\_\_

May we leave a message at the numbers provided? Y / N If Yes, at which number? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact phone number: \_\_\_\_\_

Referred by: \_\_\_\_\_ May we contact them to thank them for their referral? Y / N

Have you been to any other professional for the problems you're coming into today or a similar problem?  
If so, who and when? \_\_\_\_\_

Patient's Medical Insurance Carrier: \_\_\_\_\_

ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insured Name (if other than yourself): \_\_\_\_\_ Relation: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Payment Information**

Credit Card: (circle one) MC or Visa Credit Card Number \_\_\_\_\_

Exp Date \_\_\_\_\_ Authorizing Signature \_\_\_\_\_ Date \_\_\_\_\_

### ***Our Office Policy***

1. We do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. We do not claim responsibility of collecting your insurance claim or for negotiating a settlement of a disputed claim.
2. If you need to cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid a full service charge. A missed appointment will be charged at a full rate.
3. There is a service charge of \$35.00 for every returned check from the bank.
4. A restocking fee of \$2 per bottle will be charged for unopened, non-personalized herbal formulas. Personalized and opened herbal formulas may not be returned
5. I authorize the release of any medical records/other information necessary to process a claim with my insurance.
6. If you are under 18 years of age, please have your parent or legal guardian sign below.
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 receptionist 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

## Patient Health History

Name: \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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.*

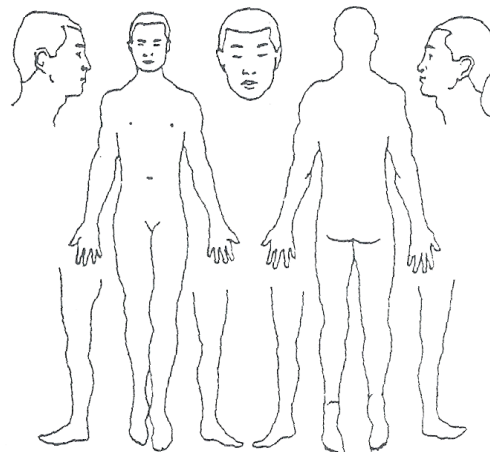
1. When and where did you last receive health care? \_\_\_\_\_  
 For what reason? \_\_\_\_\_

2. Please identify the health concern that has brought you here today:

A. \_\_\_\_\_

- When did it first occur? Or diagnosed \_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_
- Have you had this in the past? Y / N When? \_\_\_\_\_
- Related to:  accident  job injury  other \_\_\_\_\_
- Pain is:  minimal  moderate  sharp  stabbing  dull  aching  
 shooting  severe  getting worse  constant  comes and goes
- What makes your condition worse? \_\_\_\_\_
- What makes your condition better? \_\_\_\_\_

*Please mark area(s) affected*



B. Other concerns: \_\_\_\_\_  
 \_\_\_\_\_

3. 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 |

4. Sexually Transmitted Disease:  Gonorrhea  Syphilis  HPV  Chlamydia  Herpes

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

Medicine	Dosage	Reason	How Long	Doctor's name	Last check-up

6. Height: \_\_\_\_\_ Weight: Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

7. Blood Pressure: \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

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

9. **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: \_\_\_\_\_

10. **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

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

If fair or poor, why? \_\_\_\_\_

12. **Hospitalizations, Surgeries, and Accidents – please include dates, reasons for use, and outcomes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

14. <b>Family History:</b>	<u>Self</u>	<u>Paternal</u>	<u>Maternal</u>
Health (G=Good, P=Poor)	_____	_____	_____
<i>Check those applicable:</i>			
Cancer: _____	_____	_____	_____
Diabetes	_____	_____	_____
Arthritis	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis: _____	_____	_____	_____
High Blood Pressure	_____	_____	_____
Epilepsy	_____	_____	_____
Stroke	_____	_____	_____
Mental Illness	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____
Kidney Disease	_____	_____	_____

Father: Age _____ <input type="checkbox"/> Deceased
Cause of Death: _____
Mother: Age _____ <input type="checkbox"/> Deceased
Cause of Death: _____
How many siblings do you have?
Sister(s) _____
Cause of Death: _____
Brother(s) _____
Cause of Death: _____

15. **Is there anything else we should know?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please continue to the next page*

16. 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
	<b>(HT)</b>	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	<b>(SP/ST)</b>
	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 appetite
	<b>(LU)</b>	excess appetite
	sweat easily, even with little exertion	abdominal bloating or gas after eating
	cough	feeling tired after eating
	sinus congestion / pressure	prolapsed organs (previously diagnosed)
	dry mouth, throat, nose or skin	bruise easily
	allergies / hay fever	general feeling of heaviness in the body
	catch colds and flus easily	mental sluggishness/ forgetfulness/exhaustion
	asthma	swollen hands / feet
	frequent sore throats	burning sensation after eating
	chills alternating with fever	bad breath
	stiff neck / shoulders	mouth sores (canker sores)
	difficult breathing	bleeding, swollen painful gums
	<b>(LV)</b>	heartburn / belching
	diarrhea alternating with constipation	stomach pain / stomach ulcer
	tight feeling in the chest	vomiting
	bitter taste in the mouth	varicose veins
	blood shot eyes / dry eyes	eczema/hives
	anger easily	anemia
	skin rashes	constipation
	headache – location:	hemorrhoids
	numbness of hands and feet	diarrhea
	muscle spasms, twitching, cramping	<b>Allergies/Sensitivities</b>
	seizure / convulsions	Animal hair/dander
	see floating black spots	Chemicals:
	blurred vision	Dust, molds
	one-sided pain/discomfort	Food:
	pain/tenderness in the ribs	Grasses, weeds, pollen
	cold hands/feet	Medication:
	Neck and shoulder tension/pain	Others:

**17. Men Only**

Please put a check mark by the symptoms that pertain to you.

- |  |  |
|--|--|
| <input type="checkbox"/> Feeling of coldness or numbness in the external genitalia | <input type="checkbox"/> Low sex drive             |
| <input type="checkbox"/> Pain or swelling of testicles                             | <input type="checkbox"/> Lack of sex drive         |
| <input type="checkbox"/> Premature ejaculation                                     | <input type="checkbox"/> Discharges                |
| <input type="checkbox"/> Impotence / erectile dysfunction                          | <input type="checkbox"/> Painful/burning urination |
| <input type="checkbox"/> Prostate problem  | Other:   |

**18. Women Only**

Please answer each question.

- |  |                                 |
|--|---------------------------------|
| A. Are you currently pregnant now? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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. The flow is: <b>normal, heavy, light/scanty</b>   |                                 |
| H. The color is: <b>normal, dark, purple, light brown, brown, bright red, light red / pink</b><br>(circle as many that apply)                                  |                                 |
| I. Are you on birth control? Y / N   |                                 |
| J. If you are on birth control to regulate your menses, please describe what your menses was like prior to going on the pill (e.g. irregular, painful, heavy): |                                 |

Please check the appropriate responses.

- |  |  |
|--|--|
| <input type="checkbox"/> menopausal symptoms       | <input type="checkbox"/> vaginal discharge           |
| <input type="checkbox"/> premenopausal symptoms    | <input type="checkbox"/> nipple discharge            |
| <input type="checkbox"/> PMS                       | <input type="checkbox"/> vaginal itching             |
| <input type="checkbox"/> bleeding between cycles   | <input type="checkbox"/> endometriosis               |
| <input type="checkbox"/> low back pain             | <input type="checkbox"/> fibroids                    |
| <input type="checkbox"/> Painful periods           | <input type="checkbox"/> ovarian cysts / PCOS        |
| <input type="checkbox"/> blood clots               | <input type="checkbox"/> UTIs                        |
| <input type="checkbox"/> irregular cycle           | <input type="checkbox"/> polyps                      |
| <input type="checkbox"/> breast lumps / tenderness | <input type="checkbox"/> pelvic inflammatory disease |
| <input type="checkbox"/> difficulty conceiving     | <b>Operations:</b>                                   |
| <input type="checkbox"/> water retention           | <input type="checkbox"/> Cervix                      |
| <input type="checkbox"/> missed periods            | <input type="checkbox"/> Uterus                      |
| <input type="checkbox"/> food cravings:            | <input type="checkbox"/> Ovaries                     |
| <input type="checkbox"/> fatigue w/periods         | <input type="checkbox"/> others:                     |
| <input type="checkbox"/> headaches w/periods       |  |

Please continue to the next page

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 \_\_\_\_\_
- What percent of your food  
food do you prepare  
yourself? \_\_\_\_\_%

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

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

• Please specify: \_\_\_\_\_

e. Any nutritional concerns you would like to discuss? \_\_\_\_\_

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

	Yes	No	Daily Amount		Yes	No	Daily Amount
Coffee/Black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water intake	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____

g. Exercise routine: \_\_\_\_\_

h. Spiritual practice: \_\_\_\_\_

i. Occupation: \_\_\_\_\_ Hours working/week: \_\_\_\_\_

j. Do you enjoy work? Y / N Why/Why not? \_\_\_\_\_

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

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

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

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

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

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

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

Explain: \_\_\_\_\_

r. Daily T.V. viewing habits: \_\_\_\_\_ Daily Reading habits: \_\_\_\_\_

s. Interests and hobbies: \_\_\_\_\_

t. If there was one thing you could do, make, or create... given all the resources you needed to succeed ... what would it be / what would you do? \_\_\_\_\_

*Thank you!*

**Luriko P. Ozeki, L.Ac.**  
**Iyashi Wellness**  
**2001 S. Barrington Ave., Ste 111, 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 practice's 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 and 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 complain 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): \_\_\_\_\_