FUJII ACUPUNCTURE & HERBAL MEDICINE

PERSONAL HEALTH INTAKE

CONFIDENTIAL CONTACT FORM

_____ _____ _____ _____/_____/_____ _____yrs _____
First Name | Last Name | MI | Date of Birth | Age | Sex

_____ _____ _____ _____
Address | City | State | Zip

(_____) _____ - _____ (_____)_____ - _____ (_____)_____ - _____
Home Phone | Cell Phone | Work Phone

_____ Circle the best contact: → (Home) (Cell) (Work) (Email)
Email

I give permission to Fujii Acupuncture & Herbal Medicine to leave a voicemail/email regarding my appointments: Yes / No

_____ _____/_____ Marital Status → (Single) (Married) (Divorced) (Other)
Occupation | Hours / Week

_____ _____ (_____)_____ - _____
Emergency Contact | Relationship to Patient | Phone Number

_____ _____ _____
Responsible Party (If Patient is Under 18) | Relationship to Patient | Signature

Whom my we thank for referring you? _____

Seeking treatment for an injury? Y / N ❑ Work ❑Auto ❑Other _____ Date of Injury _____/_____/_____

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PRIMARY HEALTH CONCERNS (List in order of concern to you)

Health Concern	Onset (June '78)	Frequency (2x/wk)	Severity 1 (mild) – 10 (severe)
1)			
2)			
3)			
4)			
5)			

LIST OF INJURIES/DATES (falls, sports injuries, repetitive stress injuries, major traumas)

1) _____
2) _____
3) _____
4) _____
5) _____

Have you been in any motor vehicle accidents? (please note type/year even if it doesn't pertain to current health concern)

_____
_____
_____

Surgeries/Operations (please note year)

_____
_____
_____

Disease/Diagnosis

_____
_____
_____

Primary Care Physician _____ **Phone** _____

Specialist Physician _____ **Phone** _____

Other care/treatments received:

Type of care: _____ **Location/date:** _____

Type of care: _____ **Location/date:** _____

Type of care: _____ **Location/date:** _____

Type of care: _____ **Location/date:** _____

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List Current Medications and Supplements

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you. If a choice is given circle the appropriate one.

_____ Alcoholism/Substance Abuse
_____Anemia
_____Anxiety
_____Arthritis/Joint Disease
_____Asthma
_____Bipolar
_____Blood Clots/Phlebitis
_____Cancer (type_____)
_____Depression
_____Diabetes (type_____)
_____Digestive (UC, Crohn's, IBS, etc)
_____Easy Bleeding
_____Frequent Sinusitis
_____Gall Bladder Trouble
_____Hay Fever, Allergy, Eczema
_____Headaches (Migraines, etc)
_____Hearing Loss
_____Heart Attack/Disease/Failure
_____Heart Murmur
_____High Blood Pressure
_____High Cholesterol
_____History of Infertility
_____Kidney Disease/Stones
_____Liver Disease (Hepatitis, etc)
_____Lung Disease (COPD, etc)
_____Pneumonia
_____Radiation Treatments
_____Rheumatic Fever
_____Seizures, Epilepsy
_____Skin Disease
_____Sexually Transmitted Disease (type_____)
_____Stroke
_____Tuberculosis
_____Urinary Difficulties (Incontinence, UTI, etc)
_____Vision/Eye Problems
_____Other:_____

FAMILY MEDICAL HISTORY (F=Father M=Mother S=Sibling G=Grandparent)

Place the appropriate letter(s) in the blank if someone in your family has/had any of the following:

_____ Alcoholism or Substance Abuse
_____Anemia
_____Arthritis/Joint Disease
_____Cancer (type_____)
_____Diabetes (type_____)
_____Digestive Disorder
_____Easy Bleeding
_____Glaucoma
_____Hay Fever, Allergy, Eczema
_____Headaches (Migraines, etc)
_____Heart Attack/Disease/Failure
_____High Cholesterol
_____Kidney Disease/Stones
_____Liver Disease
_____Lung Disease (COPD, CHF, Asthma, etc)
_____Mental Illness, Depression, Anxiety
_____Seizures, Epilepsy
_____Stroke
_____Suicide
_____Thyroid Disease
_____Tuberculosis
_____Ulcers
_____Osteoporosis
_____Other_____

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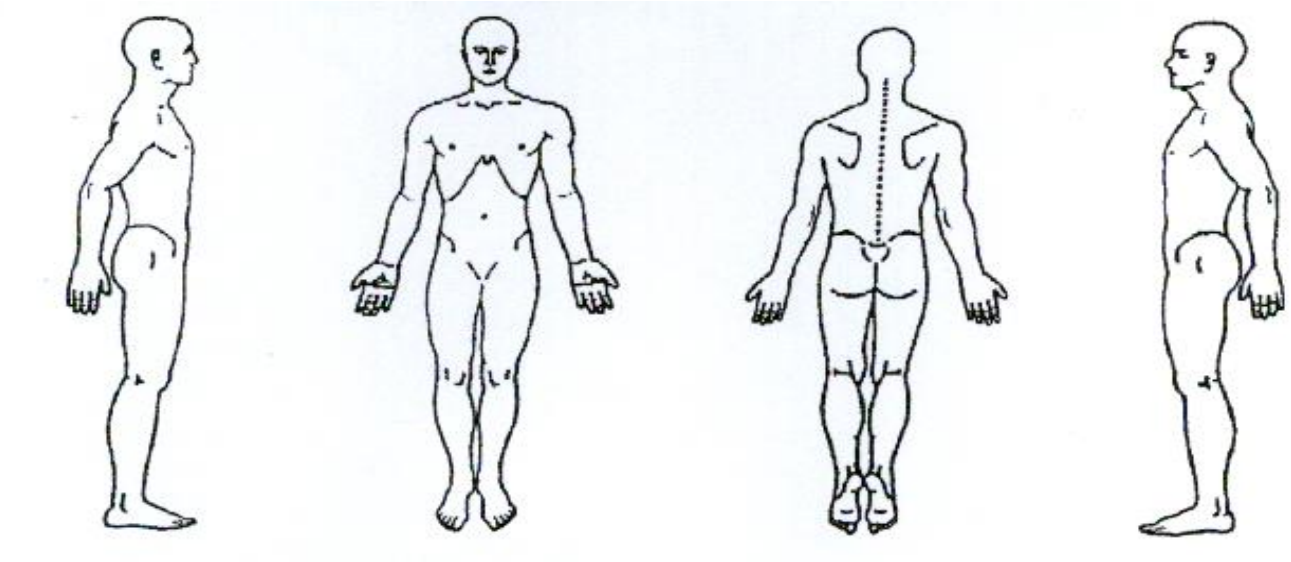

Indicate the location of pain/discomfort on the illustration. Use the symbol that best describes the feeling:

XXX Sharp/Stabbing **PPP** Pins/Needles **DDD** Dull/Aching **NNN** Numbness

LIFESTYLE

Type of Work _____ Hours/Day _____

How is work affected by your pains/health concerns? _____

_____

Average hours of sleep per night? _____ hours _____ Sleep quality (circle) **POOR FAIR GOOD**

Physical Activities/Exercise _____ Hours/Week _____

NUTRITION

Do you follow a special diet? (Vegetarian, Vegan, low carb, etc)

If yes, explain _____

Do you have any dietary restrictions?

If yes, explain _____

How many meals do you eat on average per day? (circle) 0 1 2 3 4 5 6+

Does your average meal include (circle all that apply): Grains, Vegetables, Fruit, Milk, Meat or Beans

How many glasses of water (8oz) do you drink on average per day? (circle) 0 1 2 3 4 5 6 7 8+

Do you drink coffee/caffeine? Y/N If yes, how many cups per day? (circle) 1 2 3 4 5 6 7 8+

Do you smoke? Y/N If yes, how many cigarettes per day? (circle) 1 2 3 4 5 6 7 8 9 10+

Do you drink alcohol? Y/N If yes, how many drinks per week? _____

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REVIEW OF SYSTEMS (please check all that apply)

Musculoskeletal
- ❑ Pain or swelling in joints
- ❑ Muscles become easily fatigued
- ❑ Muscle aches and pains
- ❑ Arthritic tendencies
- ❑ Joints are painful upon waking
- ❑ Joint pain after mild exertion
- ❑ Joint pain experienced after eating certain foods
- ❑ Abdomen tends to hang out
- ❑ Surface of abdomen is uneven and distended
- ❑ Use over the counter pain medications

Gastrointestinal
- ❑ Belching or Gas
- ❑ Heart Burn or Acid Reflux
- ❑ Bloating or abdominal discomfort shortly after eating
- ❑ Bad breath
- ❑ Aggravated by certain foods
- ❑ Diarrhea, chronic
- ❑ Undigested food in stool
- ❑ Constipation
- ❑ Nausea or vomiting
- ❑ Less than 1 bowel movement/day
- ❑ Stools are loose and unformed

Eyes
- ❑ Dark circles around the eyes
- ❑ Puffy eyelids
- ❑ Bags under the eyes
- ❑ Red eyes
- ❑ Inflamed eyelids
- ❑ Eyes are watery or itchy
- ❑ Blurred or tunnel vision
- ❑ Whites of the eyes are yellow

Ears
- ❑ Ear infections
- ❑ Ear drainage or discharge
- ❑ Itchy ears
- ❑ Ringing in the ears

Head
- ❑ Tension headaches at the base of the skull
- ❑ Splitting headache
- ❑ Dizziness
- ❑ Faintness

Mouth & Throat
- ❑ Coated tongue
- ❑ Swollen tongue
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Lump in the throat
- ❑ Dry mouth, eyes or nose
- ❑ Gag easily or need to clear throat often
- ❑ Mouth ulcers or canker sores

Skin
- ❑ Hives, cysts, boils, rashes
- ❑ Cold Sores, fever blisters or herpes lesions
- ❑ Dry flakey skin and/or dandruff
- ❑ Fragile skin
- ❑ Acne
- ❑ Itchy skin
- ❑ Dull colored skin (yellow, pale or grayish)
- ❑ Pale complexion

Nails
- ❑ Ridged nails
- ❑ White spots on nails
- ❑ Splitting nails
- ❑ Crumbling nails

Nose
- ❑ Frequent stuffy nose
- ❑ Airborne allergies
- ❑ Sinus congestion or stuffy head

Liver
- ❑ Wine makes you sick
- ❑ Easily intoxicated
- ❑ Hangovers
- ❑ Sensitive to chemicals
- ❑ Sensitive to tobacco smoke
- ❑ Hemorrhoids or varicose veins
- ❑ Bothered by aspartame
- ❑ Chronic fatigue or Fibromyalgia
- ❑ Over stimulated from caffeine
- ❑ Feet have a strong odor
- ❑ Sweat has a strong odor
- ❑ Skin has a sour or unpleasant odor

Heart & Lungs
- ❑ Asthma
- ❑ Wheezing or difficulty breathing
- ❑ Shortness of breath
- ❑ Chest congestion
- ❑ Heart races rapid heart rate
- ❑ Fast pulse at rest
- ❑ Flush or blush easily
- ❑ Heart skips beats
- ❑ Heart palpations
- ❑ Cold hands/feet
- ❑ Swelling of hands/feet

Kidneys
- ❑ Urine has a strong odor
- ❑ Pain in mid back region
- ❑ Urine is frothy
- ❑ Urinate infrequently

Mental & Emotional
- ❑ Feeling spacey, thinking seems slow or fuzzy
- ❑ Bizarre vivid or nightmarish dreams
- ❑ Depressed
- ❑ Worried, apprehensive, anxious
- ❑ Nervous or agitated
- ❑ Mentally sluggish, reduced initiative
- ❑ Difficulty concentrating
- ❑ Mood swings
- ❑ Coordination is poor
- ❑ Poor memory

Metabolism
- ❑ Pulse speeds after eating
- ❑ Night sweats
- ❑ MSG sensitivity

Weight
- ❑ Crave bread or noodles
- ❑ Crave certain foods / sweets
- ❑ Retaining water
- ❑ Excessive weight gain
- ❑ Excessive weight loss

Immune System
- ❑ Frequent infections (bladder, skin, ear, chest, sinus)
- ❑ Frequent colds or flu

Energy
- ❑ Weakness
- ❑ Easily fatigued
- ❑ Sleepy during the day
- ❑ Fatigue is persistent and extreme
- ❑ Apathetic and lethargic
- ❑ Tired even after waking

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Life Events (in last 12 months)

- ❑ Death of a spouse
- ❑ Divorce
- ❑ Marital separation
- ❑ Jail term
- ❑ Death of a close family member
- ❑ Personal injury or illness
- ❑ Marriage
- ❑ Fired from work
- ❑ Marital reconciliation
- ❑ Retirement
- ❑ Change in family member's health
- ❑ Pregnancy
- ❑ Sexual difficulties
- ❑ Addition to the family
- ❑ Business change
- ❑ Change in financial status
- ❑ Death of a close friend
- ❑ Change in work
- ❑ Change in number of marital arguments
- ❑ High financial debt
- ❑ Foreclosure / Bankruptcy
- ❑ Son or daughter leaving home
- ❑ Trouble with in-laws
- ❑ Outstanding personal achievement
- ❑ Spouse begins or stops work
- ❑ Starting or finishing school
- ❑ Change in living conditions
- ❑ Change in personal habits
- ❑ Trouble with your boss
- ❑ Change in work hours
- ❑ Change in residence
- ❑ Change in schools
- ❑ Change in sleeping habits
- ❑ Change in eating habits
- ❑ Other:_____
- ❑ Other:_____
- ❑ Other:_____

OTHER

- ❑ Food allergies
- ❑ Poor appetite
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Feel worse in moldy or musty place
- ❑ Low body temperature
- ❑ Please list any additional: _____

Females only:

Menstrual Cycle
Age of onset:_____
Length of Cycle:_____
Date of last cycle:_____

Check all that apply prior/during/after period:
- ❑ Painful periods
- ❑ Heavy bleeding
- ❑ Scanty bleeding
- ❑ Missed periods
- ❑ Spotting: prior/during/after
- ❑ Breast pain/tenderness: prior/during/after
- ❑ Severe cramping: prior/during/after
- ❑ Irritability/depression: prior/during/after
- ❑ Depression: prior/during/after

Pregnancy
Pregnant? Yes / No
pregnancies: _____
children: _____
miscarriages: _____
abortions: _____
Other: _____

Contraception
- ❑ Birth control pills? Type:_____
- ❑ IUD: copper/hormonal?
- ❑ other:_____

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FUJII ACUPUNCTURE & HERBAL MEDICINE POLICIES (please read, initial, & sign below)

I, _____, understand and agree to the following:

OFFICE POLICIES

Cancelation Policy: In fairness to other patients and practitioners, there is a cancelation fee of $45.00. We understand that life happens so if you need to reschedule your appointment please call within 24 hours in advance of your scheduled appointment time. If due to a medical/family/life emergency this fee may be waived and reviewed on as needed basis. _____Initial

CONSENT FOR RELEASE OF INFORMATION

I have been offered a copy and read and understood Fujii Acupuncture & Herbal Medicine's Patient Privacy Disclosure. _____Initial

Fujii Acupuncture & Herbal Medicine respects your privacy. We understand that your personal health information (PHI) is very sensitive. We will not disclose your information to others unless you allow us to do so, or unless the law authorizes us to do so. _____Initial

Federal and state laws allow us to disclose your PHI for purposes of treatment and health care operations. State law requires us to get your written authorization to disclose this information for payment purposes.

I, authorize Fujii Acupuncture & Herbal Medicine:

1. The release, use and disclosure of my PHI under the Health Insurance Portability & Accountability Act's (HIPAA) Privacy Rule to any and all of my health care providers to facilitate my health care and any and all of my insurance companies to facilitate the processing of my claims. _____Initial
2. To release any and all of my insurance/medical information to my spouse, significant other and/or family member(s). _____Initial
3. To call me at any phone number I have provided to Fujii Acupuncture & Herbal Medicine and leave a message at any of these phone numbers as necessary. _____Initial

FINANCIAL POLICIES & AGREEMENTS

1. I am solely responsible for the expenses of my care and/or the care of my dependents . _____Initial
2. I understand that payment is due at the time of service (cash, check, card). _____Initial
3. I understand that Fujii Acupuncture & Herbal Medicine is not contracted with insurance companies but upon asking will provide me with paperwork so that I can contact my insurance for reimbursement. _____Initial

By signing below I, the patient, acknowledge that I have read the above statements regarding my care and treatment at Fujii Acupuncture & Herbal Medicine. This consent will remain in effect until revoked by me, the patient, in writing.

Patient/Responsible Party Signature	Printed Name of patient	Date

Responsible Party Printed Name	Relationship to patient	Date

FUJII ACUPUNCTURE & HERBAL MEDICINE

First Name	Last Name	MI	Date of Birth	Age	Sex
			/ /	yrs	

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature	*(Date)*

(Or Patient Representative) ***(Indicate relationship if signing for patient)***