Akiko Maruyama L.Ac. **Health History Form**

Today's date M_____D_____Y_____

Name_____ Age _____ Gender: F M (Check one)

Date of Birth M_____D_____Y_____Place of Birth_____

Phone (H)_____(W)_____(C)_____

Address_____

City _____ State _____ Zip _____

E-mail _____

Do you prefer an appointment reminder? Yes No

If yes, what is your preferred contact method: _____

Height _____ Weight _____ Marital/Partnership Status _____

Profession_____

Family Physician _____ Referred By _____

Emergency Contact _____Phone_____

Have You Been Treated By Acupuncture or Oriental Medicine Before? ☐Yes ☐No

Main Problem(s) you would like help with

1. _____ Date of onset _____
2. _____ Date of onset _____
3. _____ Date of onset _____
4. _____ Date of onset _____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____

_____

_____

Have you been given a diagnosis for this problem: If so, what? _____

_____

What kinds of treatment have you tried? _____

_____

Past Medical History (please include date):

☐Cancer _____☐Depression _____ ☐Diabetes _____

☐Hepatitis _____ ☐High Blood Pressure _____

☐Heart Disease _____ ☐Rheumatic Fever_____

☐Thyroid Disease _____ ☐Seizures _____ ☐STDs_____

☐HIV/AIDS _____

☐Other

_____

Surgeries (type of and date) _____

_____

Significant Trauma (illness, auto accidents, falls, etc) _____

_____

Childhood trauma

_____

Significant Dental Work (type and date) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check):

☐Diabetes ☐Cancer ☐Depression ☐High Blood Pressure ☐Heart Disease ☐Stroke

☐Seizures ☐Asthma ☐Allergies

☐Other

_____

Medication/Supplements taken within the last 2 months (vitamins, drugs, herbs, etc)

Name of medication/supplements	Reasons for taking it
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

_____ _____

_____ _____

Occupational Stress (physical, chemical, psychological, etc) _____

_____

Emotion: Which types of emotion do you feel most of your day? (sad, depressed, calm, anger, worry, happy, etc)_____

Do you have a regular exercise program? ☐Yes ☐No

Please describe

_____

Have you ever been on a restricted diet? ☐Yes ☐No

What Kind?

_____

Are you a smoker? ☐Yes ☐No ☐Quit

If so, how many **packs of cigarettes** do you smoke per day? _____/day

How many **caffeinated** beverages (tea, coffee, soda, energy drinks) do you drink per day? _____

How much **alcohol** do you drink **per week**?_____

How much **water** do you drink **per day**? _____

Please describe any use of recreational drugs _____

Meals of your typical day:

Breakfast

_____

Lunch

_____

Dinner

_____

Please check any problems you have had in the **last 3 months**:

General

Head, Eyes, Ears, Nose, Throat

☐Poor appetite
☐Fevers
☐Chills
☐Sweat easily
☐Localized weakness
☐Bleed or bruise easily
☐Peculiar tastes or smells
If yes, _____
☐Strong thirst (cold or hot)
☐No desire to drink
☐Sudden energy drop
When? _____
☐Poor sleep
☐Tremors
☐Poor balance
☐Fatigue
☐Night sweats
☐Cravings
_____
☐Change in appetite
☐Weight gain
☐Weight loss

Skin and Hair

Rashes

☐Itching
☐Dandruff
☐Change in hair or skin
☐Ulcerations
☐Eczema
☐Loss of Hair
☐Hives
☐Pimples
☐Recent Moles
☐Other hair or skin problems
_____
_____

Musculoskeletal

☐Muscle pain, where?
_____
☐Muscle weakness
☐Neck pain
☐Shoulder pain
☐Hand/wrist pain
☐Back pain
☐Elbow pain
☐Hip pain
☐Knee pain
☐Foot/ankle pain

Head, Eyes, Ears, Nose, and Throat

☐Dizziness
☐Poor vision
☐Cataracts
☐Eye strain
☐Night blindness
☐Blurry vision
☐Spots in front of eyes
☐Eye pain
☐Color blindness
☐Earaches
☐Ringing in ears (tinnitus)
☐Poor hearing
☐Sinus problems
☐Grinding teeth
☐Teeth problems
☐Jaw clicks
☐Facial pain
☐Nose bleeds
☐Recurrent sore throats
☐Sores on lips or tongue
☐Concussions
☐Migraines
☐Headaches – where and when? _____
_____

☐Other Head or neck problems
_____
_____

Cardiovascular

☐High blood pressure
☐Irregular heart beat
☐Cold hands and feet
☐Blood clots
☐Low blood pressure
☐Dizziness
☐Swelling of hands
☐Swelling of feet
☐Phlebitis
☐Chest pain
☐Fainting
☐Difficulty in breathing
☐Other heart or blood vessel problems _____
_____

Respiratory

☐Cough
☐Bronchitis
☐Pneumonia
☐Asthma
☐Tuberculosis
☐Pain with a deep breath
☐Difficulty in breathing when lying down
☐Production of phlegm
What color _____
☐Coughing blood
☐Other Lung problems -
_____
Approximately when was your last cold or flu? _____
_____

Gastrointestinal

☐Nausea
☐Vomiting
☐Constipation
☐Diarrhea
☐Chronic laxative use
☐Bad breath
☐Belching
☐Burning sensation

☐Stomach ache
☐Abdominal pain or cramps
☐Gas
☐Indigestion
☐Blood in stools
☐Black stools
☐Rectal pain
☐Rectal burning
☐Anal Prolapse
☐Hemorrhoids
☐Other stomach or intestinal problems _____
_____

Pregnancy and Gynecology
Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
_____
☐Irregular period
_____
☐Painful periods
☐Vaginal discharge
What color? _____
☐Changes in body/psyche prior to menstruation
_____
_____
_____
☐Clots
☐Vaginal sores
☐Vaginal dryness
Last Pap smear _____
_____
☐Breast lumps
_____
☐Fibroids Cysts
_____

☐Lack of libido
☐Dizziness after intercourse
☐STD
Which? _____
☐Are you sexually active?
_____
Do you practice birth control?
☐Yes ☐No ☐N/A
if yes, what types for how long?
_____

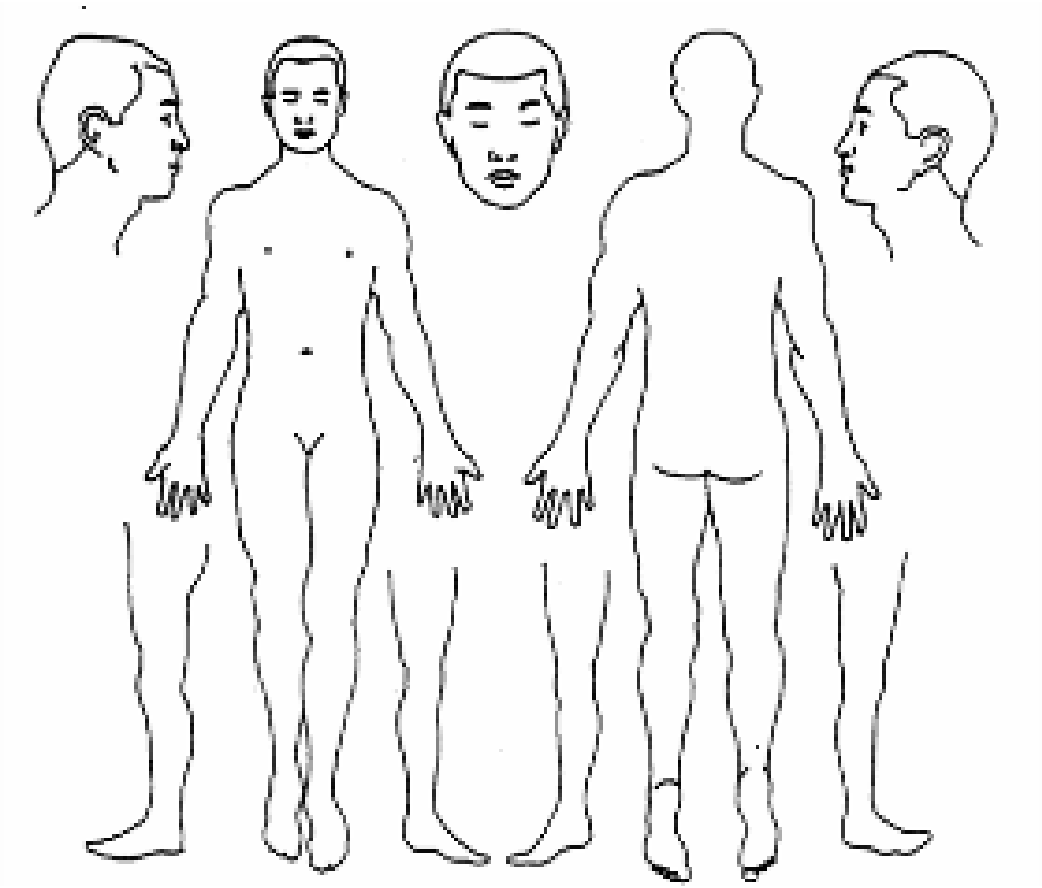
☐Sores on genitals
☐Impotency
☐Premature ejaculation

Urination
☐Pain on urination
☐Urgency to urinate
☐Frequent urination
How often _____
☐Unable to hold urine
☐Urinary difficulty
☐Night Urination
☐Blood in urine

Neuropsychological
☐Seizures
☐Stroke
☐Tremors
☐Fainting spells
☐Areas of numbness
☐Concussion
☐Poor memory
☐Dizziness
☐Vertigo
☐Loss of balance
☐Lack of coordination
☐Depression
☐Easily stressed
☐Bad temper
☐Anxiety
☐Difficulty concentration
☐Insomnia
☐Hard to falling asleep
☐Hard to stay asleep
☐Restless sleep
☐Hard to falling back to sleep
☐Nightmare
☐Wake up too early

Use the following illustration to indicate painful or distressed areas:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness



Notice of Privacy Policies
Akiko Maruyama, L.Ac.

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of the acupuncturist: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, the acupuncturist is required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by the acupuncturist. This notice will be in effect until it is replaced.

The acupuncturist reserves the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. The acupuncturist reserves the right to make the modifications effective for all protected health information that the acupuncturist maintain, including protected health information the acupuncturist created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services the acupuncturist provided to you.

We accept cash and check. Returned checks will be subject to a $35.00 NSF fee.

Healthcare Processes: The acupuncturist may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, the acupuncturist will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. The acupuncturist will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if the acupuncturist has reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If the acupuncturist has reason to believe the use or disclosure of

your protected health information will prevent a serious threat to your health or safety or the health or safety of others the acupuncturist may have to provide the necessary protected health information.
National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.
Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. The acupuncturist may also write a thank you card to whomever referred you to her practice.
Patient Rights Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, the acupuncturist will provide your information in a format other than photocopies. If the acupuncturist is able to do so, your request will be accommodated.
Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. The acupuncturist may need to charge you a reasonable cost- based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, the acupuncturist will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, the acupuncturist will charge a cost based fee for that format. An explanation of fees can be made available.
Disclosure Accounting: Your rights include the choice to receive a review of every time the acupuncturist disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.
Restrictions: You may request the acupuncturist apply additional restrictions to any disclosure of your healthcare information. The acupuncturist is not required to respond to the application of these additional restrictions. If the acupuncturist agrees to follow your request regarding additional restrictions, the acupuncturist will follow the agreed restrictions unless an emergency situation dictates otherwise.
Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.
Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where the acupuncturist may reject your request.
Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.
Questions and Complaints: If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision the acupuncturist made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have the acupuncturist communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. The acupuncturist will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.
Privacy of your protected health information remains extremely important; the acupuncturist is committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, the acupuncturist will not retaliate in any way. The acupuncturist is available to assist you with any questions, concerns, or complaints.

Cancellations of Appointments: Please be courteous and call Aki Healing Arts promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled office appointment we require that you give **at least 48 business hours in advance notice**. (Sundays/Holidays do not count.)Your early cancellation will give another person the possibility to have access to timely acupuncture treatment.

- You will be charged to $50 for 60 min app and $65 for 90 min app when giving me a notice of less than 48 hours prior to your appointment time.
- You will be charged to $100 for 60 min app and $130 for 90 min app when giving me a notice of less than 24 hours of cancellation or no show.
- This missed appointment fee and cancellation fee will not be covered by your insurance. It's your own responsibility to pay

I have read and understood the privacy policies of Akiko Maruyama, LAc.

Signature of patient _____ Date _____

Or
Relationship to Patient (if applicable)_____ Date _____

Your Credit Card Information:

Name on the card: _____

Card Type: Visa Master Amex Discover

Number on the card:

_____-_____ -_____- _____

Expiration Date: _____

CVV: _____

Your Billing Zip Code: _____