Koyama Chiropractic and Acupuncture Clinic

12629 West Washington Blvd. Los Angeles, CA 90066 | Telephone: 310-391-6125 | FAX: 310-391-7117

Date: _____

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Telephone: (H) _____ (C) _____

Email: _____

Date of Birth (mm/dd/yr): _____ Social Security#: _____

Age: _____ Gender: M / F Ht: _____ Wt: _____ Marital Status: _____

Occupation: _____ Employer/Phone#: _____

Emergency Contact: _____ Relationship: _____

Home#: _____ Cell#: _____

How did you hear about us? Please specify (Facebook, VJCC etc): _____

Whom may we thank for your referral? _____

Primary physician: _____ Ph#: _____ Fax#: _____

Address: _____

City: _____ State: _____ Zip: _____

Result/diagnosis: _____

Date of last physical exam: _____ Date of next physical exam: _____

Are you claiming all or part of our fee under insurance? If so, please provide:

Name of Primary Insurance Company: _____

Name of Responsible Party/Spouse: _____

Social Security# of Insured: _____ Birth Date of Insured: _____

Policy ID#: _____ Group#: _____

Name of Secondary Insurance Company: _____

Name of Responsible Party/Spouse: _____

Social Security# of Insured: _____ Birth Date of Insured: _____

Policy ID#: _____ Group#: _____

Have you ever had any *acupuncture* treatment before? Yes & When: _____ No

Name of Previous Acupuncturist: _____ Date of Last Visit: _____

Brief description of your experience: _____

NEW PATIENT QUESTIONNAIRE

Primary Complaint: _____

_____

_____

How long have you had? _____ If you had this before, when? _____

What makes it better? _____ What makes it worse? _____

If experiencing pain, intensity in the pain scale 1-10: _____ (0: no pain and 10 worst pain ever)

What kind of pain? (stabbing, dull etc) _____

List all surgery/injury/hospitalization (Also list **dates**)

_____

_____

_____

_____

Do you currently have? ☐ Pacemaker ☐ Metal Implants ☐ Pregnant

Allergies: _____

Please indicate if you had (or currently have) any of the following:

☐Hepatitis ☐HIV (AIDS) ☐Skin disease (or infection) ☐Herpes ☐STD

☐Other infectious disease: _____

Medications (List all including prescription drugs, vitamins, supplements, herbs)

Name: _____ For: _____ Dosage: _____ How long: _____

Name: _____ For: _____ Dosage: _____ How long: _____

Name: _____ For: _____ Dosage: _____ How long: _____

Name: _____ For: _____ Dosage: _____ How long: _____

Name: _____ For: _____ Dosage: _____ How long: _____

Have you experienced any of the following in the last 12 months?

Recurring persistent infection in ☐bladder ☐skin ☐gums ☐genitals

☐Sudden weight loss of 10 pounds or more ☐Bruise easily ☐Decreased energy

☐Change in bowel function (constipation, diarrhea, black stool, difficulty controlling): _____

☐Change in urinary function (frequency, incontinence, dark urine, bloody): _____

YOUR **Medical History**

☐Cancer ☐HIV ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Low Blood Pressure ☐Stroke ☐Epilepsy ☐Asthma ☐Kidney Disease ☐Anemia ☐Bleeding Disorder ☐STD ☐Hepatitis ☐Jaundice ☐Thyroid Disease ☐Chronic Fatigue ☐Sudden Weight Gain

Others _____

FAMILY **Medical History**

☐Cancer ☐HIV ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Low Blood Pressure ☐Stroke ☐Epilepsy ☐Asthma ☐Kidney Disease ☐Anemia ☐Bleeding Disorder ☐Hepatitis ☐Thyroid Disease

Please check if any problems below that are frequent or have had within the last 3 months.

HEAD/EYES/EARS/NOSE/THROAT

☐Dizziness ☐Concussion ☐Poor Memory ☐Loss of Balance ☐Heaviness in the head ☐Migraines ☐Headache (describe) _____

☐Eye Strain ☐Eye Pain ☐Floaters ☐Blurred Vision ☐Dry Eye ☐Watery Eye ☐Itchy Eye

☐Ear Pain ☐Ear Infection ☐Hearing Loss ☐Ringing in Ears ☐Grinding Teeth ☐TMJ ☐Teeth Problems ☐Facial Pain ☐Facial Paralysis ☐Sinus Problems ☐Runny Nose ☐Congestion ☐Mucus ☐Nose Bleed ☐Frequent Colds ☐Sore Throat ☐Copious Saliva ☐Dry Mouth ☐Difficulty Swallowing ☐Hoarseness/Loss of Voice ☐Sensation of Lump in Throat ☐Tongue Ulcer ☐Tongue Pain ☐Mouth Ulcer

RESPIRATORY SYSTEM

☐Shortness of Breath ☐Difficulty Breathing ☐Wheezing ☐Cough ☐Asthma ☐Bronchitis ☐Pneumonia ☐Cough Blood ☐Phlegm - Color _____Thick or Thin? _____

HEART SYSTEM

☐Insomnia ☐Heavy Sleep ☐Difficulty Falling Asleep ☐Wake Easily ☐Nightmares ☐Difficulty Staying Asleep ☐Wake Frequently ☐Wake Early Time? _____ ☐Snoring ☐Excess Dreaming ☐Restless Sleep ☐Night Sweat ☐Sleep Apnea ☐Fainting ☐Vertigo ☐Dizziness ☐Tremors ☐Fatigue ☐Restless ☐Cold Feet ☐Cold Hands ☐Swollen Hands/Feet ☐Cold Back ☐Localized Weakness ☐Fever ☐Chills ☐Chest Pain/Tightness ☐Irregular Heart Beat ☐Palpitation ☐High Blood Pressure ☐Low Blood Pressure

SKIN/HAIR

☐Frequent Rashes ☐Eczema ☐Hives ☐Itching ☐Purpura ☐Dryness ☐Clammy/Moist ☐Burning ☐Changes in Moles or Lumps ☐Bleed/Bruise Easily ☐Varicose/Spider Veins ☐Hair Loss ☐Dry Scalp ☐Change in Hair Texture ☐Scars ☐Other _____

DIGESTIVE SYSTEM

☐Poor Appetite ☐Excess Hunger ☐Bloating ☐Cold Abdomen ☐Thirst ☐Heartburn ☐Nausea ☐Vomiting ☐Belching ☐Foul Breath ☐Stomach Pain ☐Flatulence ☐Acid Reflux ☐Hemorrhoids ☐Specific Food Craving? _____BOWEL MOVEMENT: Frequency (#/day) _____ Color _____ Loose or Firm?

☐Foul Odor ☐Diarrhea ☐Constipation ☐Black Stools ☐Bloody Stools ☐Mucous Stools

☐Colitis ☐IBS ☐Sudden Energy Drops at _____ (time) ☐Fatigue ☐Heavy Limbs ☐Weak Limbs

URINARY SYSTEM

☐Painful/Burning Urination ☐Pain before Urination ☐Urgency to Urinate ☐Incontinence ☐Blood in Urine ☐Kidney Stones ☐Frequent Infections ☐Strong Urine Smell ☐Frequent Urination Day or Night? _____ ☐BHP (Enlarged Prostate) ☐Elevated PSA ☐Impotence

☐Urine Color: _____ ☐Amount: _____

NEUROLOGICAL & PAIN

☐Seizures ☐Epilepsy ☐Tremors ☐Numbness/Tingling ☐Always Cold ☐Always Hot ☐Poor Coordination ☐Neuralgia (pain) ☐Shingles ☐Bell's Palsy ☐Sciatica ☐Low Back Pain ☐Shoulder Pain ☐Muscle Spasm/Cramp ☐Muscle Weakness ☐Other _____

EMOTIONAL

☐Nervousness ☐Depressed ☐Anxiety/Worry ☐Easily Angered ☐Easily Irritated ☐Stressed ☐Sadness/Grief ☐Frequent Crying ☐Mood Swings ☐Suicidal ☐Phobias/Fears ☐Manic ☐Panic Attacks ☐Indecisive ☐Sigh a lot ☐Other Emotional

_____

REPRODUCTIVE SYSTEM (for Women)

☐Pregnant? # of Pregnancies _____ # Deliveries _____ # Miscarriages _____ # Abortions _____

Age Began Menstrual Cycle _____ Age Stopped _____ On Birth Control? Method_____

Period Cycle (frequency) _____ days Period Duration _____ days Last Period began:____/_____/_____

Last PAP _____ Color (bright red/dark red/red/pale/purple) _____

☐Heavy Flow ☐Light Flow ☐Clots ☐Cramps/Pain ☐Irregular Cycle ☐Scanty Flow ☐Missed Periods ☐Dysmenorrhea ☐Bleeding between Periods ☐PMS

☐Vaginal Discharge - Color _____ Thick or Thin? _____ ☐Itching ☐Odor

☐Breast Lumps ☐Breast Pain ☐Nipple Discharge ☐Fibroids ☐Endometriosis ☐Low Libido ☐Painful Intercourse ☐Abdominal Pain ☐Low Backache ☐Water Retention ☐Menopause ☐Hot Flashes ☐Mood Swing

Other _____

LIFE STYLE QUESTIONNAIRE

Are you a smoker? If so, how many a day? _____

Do you drink alcohol? If so, what kind, how often and how much? _____

Do you exercise? Type & Frequency: _____

Do you? ☐Skip meals ☐Snack ☐Eat large meals ☐Eat when rushed ☐Work and eat

Please write down your **diet** for the last 3 days:

	Breakfast	Lunch	Dinner	Snack
Day 1				
Day2				
Day 3				

******Clinic Use******

Energy:	B/M:
HA:	Sleep:
F/Ch:	Menstruation:
N/V:	Pulse speed: depth: qty:
Thirst:	Tongue body: coat:
Sweat:	Dx:
Digestive:	Tx:
Appetite:	
Urine:	

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OUR PATIENT CARE FINANCIAL AGREEMENT POLICY

Dear Patient,

Thank you for choosing Koyama Chiropractic and Acupuncture Clinic, as your healthcare provider. We are committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions.

Missed Appointments and Cancellations

In order to prevent being charged a cancellation fee we agree to, give at least 24 hours notice of cancellation. Sufficient cancellation notice allows us to offer your time to another patient who may be waiting for an appointment. Uncanceled or missed appointments without 24 hours notice will be charged full amount. For patients arriving more than 15 minutes late, you may be asked to reschedule your appointment if there is not sufficient time to provide the best treatment to you, or to have shortened session. We will do our best to provide sufficient treatment as schedule permitted. Please help us provide the best care to you by keeping scheduled appointments in a timely manner. Late cancellation due to emergencies are understandable, in those cases the cancellation fee will be waived.

Insurance

Please remember that medical services are rendered to you, not to your insurance company. Check with your insurer to find out if chiropractic or/and acupuncture is/are included in your benefits. We are happy to verify your coverage for you after your first session. Important: until we can verify your coverage, payment is due in full at the time of each visit. If you have insurance that covers chiropractic and acupuncture, we will do our best to determine what co-pay amount you are responsible for. We will submit and process your claims to receive partial payment. The full cost of services is ultimately your responsibility, even if your insurance provider denies payment for any portion of your bill for any reason. Some insurance companies send payments directly to the patient. In this case, we ask that you pay for services in full at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance programs. Insurance companies do not reimburse for cancelled sessions. Please note that supplements and/or herbal formulas supplied as part of your treatment are no typically covered by insurance.

Rate Schedule

- Comprehensive New Patient Initial Consultation, including Acupuncture Treatment: $120.00
- Established Patient Consultation & Acupuncture Treatment: $80.00
- Cosmetic Facial Rejuvenation Acupuncture Treatment: $120.00
- Cupping/Moxibustion/Electric-Stimulation/Gua Sha: $20 each
- Herbal Medicines/Supplements: prices vary from $30 - $50

Herbal tablets, pill or supplements may be returned unopened for a full refund. No returns or refunds on custom herbal medicine extracts and teas. There is a $25 fee for all returned checks. Payment is due in full at time of service.

My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.

X_____ **Date** _____

Signature of Patient or Responsible Party

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PRIVACY RIGHTS/HIPAA NOTICE

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, your may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Authorization for other uses of Protected Health Information (PHI)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose: Office promotions, holiday/birthday cards, newsletters, change of address for individuals who may use or disclose this information.

Expiration date of this Authorization: Ongoing until patient indicates in writing otherwise

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

I hereby acknowledge that I have received a copy of Koyama Chiropractic and Acupuncture Clinic's Notice of Privacy Practices.

Patient Name (Please Print) _____

Patient Signature _____ Date _____