Fremont Holistic Center: Shibuya Integrative Health - Informed Consent & Office Policies

Our commitment here at the Fremont Holistic Center is to serve our patients with professionalism and genuine concern, being sure at all times to protect the privacy and security of all protected health information. During the course of serving you, it may be necessary to share pertinent information with other health care providers or associates for the purpose of ordering laboratory tests, determination of fees, collection of fees, scheduling of your appointments or to obtain a second opinion. If any other uses or disclosures other than the ones listed above (treatment, payment or health care operations) are needed, information will be released only with your written consent, as provided for by law.

As a patient of the Fremont Holistic Center, you acknowledge that you will be receiving treatments from traditional healing systems, also known as “complementary” or “alternative” therapies, which are generally NOT utilized in Western allopathic medicine. Furthermore, you also acknowledge that both traditional and allopathic therapies may be beneficial for you and you may use them simultaneously and that you will actively participate and keep all of your practitioner(s) involved in your care aware of your participation in the others’ care to facilitate optimal outcomes and to minimize side effects.

All health and laboratory information will be given at scheduled office or phone appointments. Please be aware when scheduling phone appointments, our normal fees- for- service apply. If you need to have lab tests and are unable to make an appointment, we will fax them to another doctor, but will not send them to you directly unless you have already discussed them with the doctor.

Please be aware that Health and Safety Code section 109250, et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. If you have been diagnosed with cancer, we will be unable to treat you for this diagnosis.

We do **NOT** accept insurance nor do we submit claims to insurance companies. We ask that you know your insurance coverage prior to visiting us. Labs, supplements, medical devices and prescriptions are not included as part of our office fees and may be billed by other parties. It is your responsibility to make payment arrangements with them. If you have insurance and wish to submit a claim, you authorize the Fremont Holistic Center to release any necessary information needed to determine your benefits, upon written request by your insurance. All payment is expected at the time of service. Debit Cards, MasterCard, VISA, cash, and checks are acceptable forms of payment.

Please be advised that if for any reason you cannot keep your scheduled procedure or appointment, we require that you cancel at least 48 business hours prior to your follow-up appointment and 72 business hours prior to your NEW patient appointment. Failure to cancel within that time frame or failure to show for the appointment will result in a $150 / $300 fee respectively. This fee may change without notice.

Thank you for your cooperation. We look forward to assisting you on your journey to wellness.

Sincerely,
Barry Shibuya, M.D. and Associates

I have read and understand this form.

Print Name: ________________________________ Signed: ________________________________

Date:______________

WOMEN'S HEALTH INTAKE FORM

PATIENT INFORMATION – Please PRINT and complete as thoroughly as possible in BLACK INK then fax back to (866) 291-4756

First Name:	Middle:	Last:	Date:
Date of Birth:	Age:		Gender: Female
Street Address:		Occupation:	
City:		State:	Zip Code:
Phone 1: ( ) □ Home □ Work □ Cell May we leave messages at this number? □ Yes □ No		Phone 2: ( ) □ Home □ Work □ Cell May we leave messages at this number? □ Yes □ No	

Email:

May we email you information about our office? □ Yes □ No

Emergency Contact (Name): Phone ( ) □ Home □ Work □ Cell

Relationship to you: May we leave messages at this number? □ Yes □ No

Who is your current **Primary Care Doctor**?

Phone: ( ) Fax: ( )

Please list other health care professionals from whom you receive **ONGOING** care (Name, specialty, phone):

Dr:	Specialty:	Phone: ( )
Dr:	Specialty:	Phone: ( )
Dr:	Specialty:	Phone: ( )
Dr:	Specialty:	Phone: ( )

How did you find our office? □ Referred by Dr: ________________________ □ Referred by current patient: ______________________

□ Online search □ ABIHM Website □ Newspaper/Magazine □ Community Talk □Word of mouth □ Other:

WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.

1.
2.
3.
4.
5.
6.

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE INTERESTED IN & RANK IN ORDER OF IMPORTANCE (#1 = MOST, #15 = LEAST)

□ Food Allergy Testing ___	□ Hormone Testing ___	□ Heavy Metal Testing ___
□ Nutritional Testing ___	□ Fertility Testing ___	□ Wellness Screening ___
□ Testing for Depression ___	□ Complete Cardiovascular Panel ___	□ Other: ___
□ Anxiety or Mental Health ___	□ Anti-aging/Preventive Medicine Testing ___	□ Digestive Analysis ___
□ Non-hormonal Birth Control ___	□ Naturopathic Pain Management ___	□ Detoxification Diet ___

What do you hope to accomplish with this holistic consultation? Please be as SPECIFIC as you can.

1.
2.
3.

PAST MEDICAL HISTORY: Please check **ALL** that apply

□ High Blood Pressure	□ Asthma/COPD	□ Cancer	□ Thyroid Disease	□ Blood Transfusion
□ High Cholesterol	□ Pneumonia	□ Epilepsy/Seizure	□ Kidney Problem	□ Hepatitis
□ Heart Attack/CHF	□ Stomach Ulcers	□ Headaches	□ Gout	□ Tuberculosis
□ Stroke	□ Colitis	□Psoriasis	□ Iritis/Uveitis	□ Deep Vein Thrombosis
□ Diabetes	□ Anemia	□ Liver Problems	□ Cataracts/Glaucoma	□ Pulmonary Embolus

Please list any **OTHER** past or present diagnoses (if any):

Please list past hospitalizations and surgical procedures (include date, hospital & reason for hospitalization)l):

Do you have all the recommended **vaccinations** for your age? □ Yes □ No □ Unsure

List any known **allergies** to medications, foods or other substances as well as your reaction(s):

Have you traveled outside the United States in the past two years? □ Yes □ No. If yes, where?

MEDICATIONS AND SUPPLEMENTS

List all current medications, vitamins, herbs and other supplements you take, including dosages and how often you take them.

Medications:	Vitamins, Herbs, Other Supplements:

FAMILY HISTORY

List any serious health conditions your family members have experienced. Include diabetes, heart disease, auto-immune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Relationship	Age	Died @ - from	Health Conditions
Father			
Mother			

SOCIAL HISTORY AND LIFESTYLE

Please list all persons and pets currently living with you:

HABITS	**Yes**	**No**	**Details**
Current tobacco use	□	□	Packs per day:
Past tobacco use	□	□	Packs per day: When did you quit?
Alcohol consumption	□	□	How often? Types: □ Beer □ Wine (Red/White) □ Hard Liquor
Recreational drug use	□	□	Types: □ In the past □ Current Use (Regularly/Occasionally)
Exposure to toxic chemicals, solvents, other harmful toxins	□	□	If yes, please explain:
Caffeine use (circle all): Coffee, tea, soda, energy drinks	□	□	Cups per day?
Regular exercise	□	□	How often? Activities:

STRESS - I have seen Dr **Phone#** **Fax#**
I have seen Dr **Phone#** **Fax#**

Current stress level: □ Low □ Medium □ High

Source of stress: □ Job □ Financial □ Family/Relationship □ Other:

Please indicate current (C) or past (P) symptoms	**C**	**P**		**C**	**P**
Tension	□	□	Nervousness	□	□
Anxiety	□	□	Irritability	□	□
Depression	□	□	Inability to concentrate	□	□
Chronic procrastination	□	□	Eating disorder	□	□

SLEEP – I have seen Dr **Phone#** **Fax#**

Problems falling asleep?	□	□	What keeps you awake?
Problems staying asleep?	□	□	
Do you wake feeling refreshed?	□	□	
Do you snore or have sleep apnea?	□	□	

NUTRITION – I have seen dietician at **Phone#** **Fax#**

Do you follow a particular diet?	Are there foods that you avoid eating? Why?
How many meals do you typically eat in a day?	Where do you buy food? Who cooks the food you eat?

Describe your typical
Breakfast:
____
Lunch:
____
Dinner:
____
Snacks & Sweets:
____
Drinks (any):any

Are you frequently thirsty?	□	□	How many cups oh water do you drink a day?

Check any of the following that you consume regularly:
□ Highly seasoned foods □ Processed foods □ Soda (Regular/Diet) □ Candy □ Juice

List foods you crave for:	List foods to which you have a reaction:

Are you satisfied with your diet?	□	□	If no, why not?

FEMALE HEALTH INFORMATION – **I have seen Dr** **Phone#** **Fax#**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Pelvic Inflammatory Disease	□	□	Fibroids	□	□
Chronic yeast or vaginal discharge	□	□	Urinary tract infections	□	□
Loss of bladder control	□	□	Breast cancer or benign tumors	□	□
Blood in urine	□	□	Painful urination	□	□
Chronic vaginal itching or burning	□	□	History or current STD If yes, which ones?	□	□

MENSTRUAL HISTORY

Date of last period:			Age at first period:
Did you have a normal puberty?	□	□	If no, why?
Are your periods currently regular?	□	□	Days between periods: Length of flow: Days of heavy bleeding: ____ Light:____ Spotting:_____
Date of last PAP:			Date of last breast exam:
Were the results normal?	□	□	Date of last mammogram:
History of abnormal PAPs?	□	□	If yes, abnormal findings:
Have you had a bone density test?	□	□	If yes, when? Results? □ Normal □ Osteopenia □ Osteoporosis

Menstruating Women: Please mark any of the following symptoms you experience before (B), during (D) or after (A) your menstrual cycle. If you do NOT have a cycle, please mark symptoms you are currently experiencing.

B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptoms	B	D	A	Symptom
□	□	□	Cramping or pain	□	□	□	Headache	□	□	□	Bloating	□	□	□	Weight gain
□	□	□	Constipation	□	□	□	Breast tenderness	□	□	□	Increased appetite	□	□	□	Sweet cravings
□	□	□	Depression	□	□	□	Nervous tension	□	□	□	Irritability	□	□	□	Mood changes
□	□	□	Forgetfulness	□	□	□	Anxiety	□	□	□	Confusion	□	□	□	Crying
□	□	□	Heart pounding	□	□	□	Insomnia	□	□	□	Fatigue	□	□	□	Insomnia

Mother's age at menopause: Sister(s): Mother's age if she is NOT menopausal:

Menopausal Women: If you are currently peri-menopausal or menopausal, do you experience any of the following symptoms? Please indicate yes (Y), no (N) or past (P).

Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom
□	□	□	Hot flashes	□	□	□	Insomnia	□	□	□	Vaginal dryness	□	□	□	Memory loss
□	□	□	Fatigue	□	□	□	Decreased libido	□	□	□	Weight gain	□	□	□	Mood changes

OBSTETRIC HISTORY - **I have seen Dr** **Phone#** **Fax#**

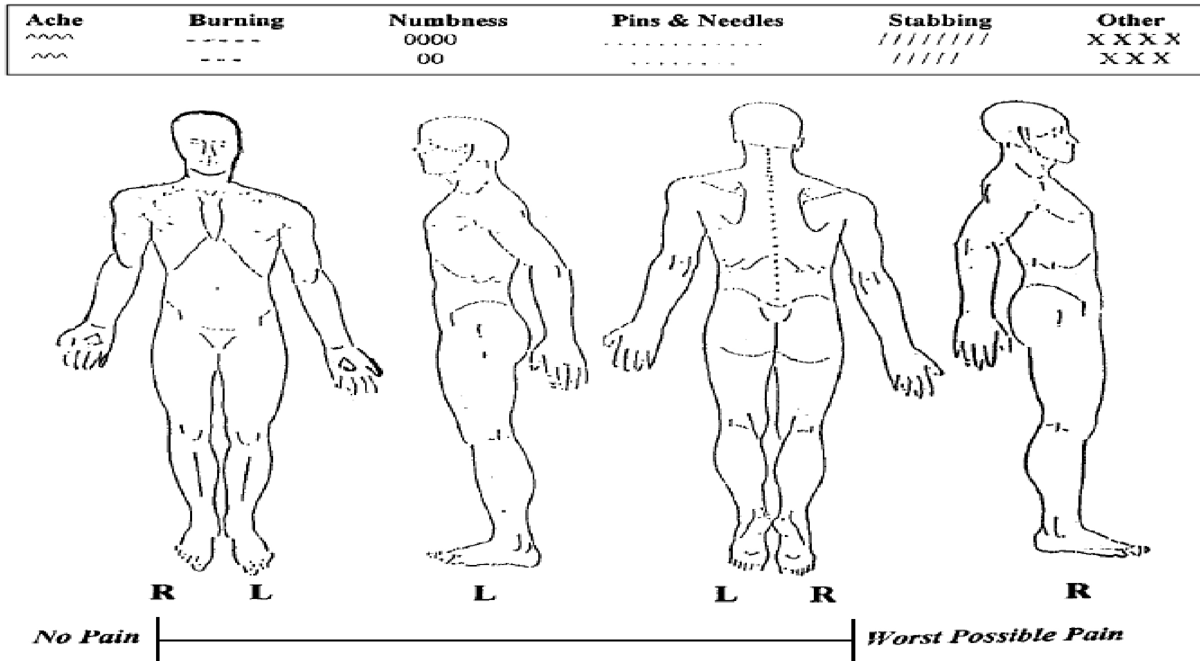
Are you currently pregnant?		□	□	
Are you trying to conceive?		□	□	
Have you had problems with infertility?		□	□	If yes, please explain:
Any pregnancy complications?		□	□	If yes, please explain:
# of pregnancies:	Live births:			Miscarriages: Abortions:
Are you currently breast feeding?		□	□	

SEXUAL HEALTH

	Yes	No	
Are you currently sexually active? □ Men □ Women □ Both	□	□	If yes, current method of contraception?
Have you ever used birth control pills?	□	□	If yes, how long?
Have you ever used an IUD?	□	□	If yes, how long & what kind?
Are you content with your libido/sex life?	□	□	Any vaginal dryness or painful intercourse? □ Yes □ No

MUSCULOSKELETAL HEALTH – **I have seen Dr** **Phone#** **Fax#**

Please use the symbols in the diagram below to describe any symptoms you may have



Over the past week, on a scale from 0 = No pain, to 10 = Worst pain imaginable, please rate:

The Worst Pain you have experienced: __________

Your Daily, Average Pain Level: __________

The Least Pain you have experienced: __________

Your Pain Right Now: __________

Over the past week, on a scale from 0 = Does Not Interfere, to 10 = Completely Interferes, please rate the effect of your pain on:

Your overall, general activity level: __________

Your mood: __________

Your ability to work (Inside & Outside the house): __________

Your personal relationships: __________

Your walking ability: __________

Your sleep: __________

Your ability to exercise: __________

Your enjoyment of life: __________

RHEUMATOLOGICAL (ARTHRITIS) HEALTH - **I have seen Dr** **Phone#** **Fax#**

DO HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Osteoarthritis (OA)	□	□	Rheumatoid Arthritis (RA)	□	□
Degenerative Joint Disease (DJD)	□	□	Ankylosing Spondylitis (AS)	□	□
Gout	□	□	Psoriatic Arthritis (PsA)	□	□
Pseudo-Gout	□	□	Inflammatory Bowel Disease (IBD) Related Arthritis	□	□
Bursitis / Tendonitis	□	□	Systemic Lupus Erythematosus (SLE)	□	□
Fibromyalgia / Chronic Fatigue	□	□	Sjogren's Syndrome	□	□
Avascular Necrosis (AVN)	□	□	Mixed Connective Tissue Disease (MCTD)	□	□
Osteoporosis	□	□	Scleroderma	□	□
Chronic Steroid Use (5 mgs/day for >3 months)	□	□	Vasculitis	□	□
Other:	□	□	Polymyalgia Rheumatica (PMR)	□	□

GASTROINTESTINAL HEALTH – I have seen Dr Phone# Fax#					
Number of bowel movements per day:			Is your stool ☐ loose or ☐ formed?		
DO HAVE A HISTORY OF ANY OF THE FOLLOWING:	**Yes**	**No**		**Yes**	**No**
Do you tend to have: ☐ constipation or ☐ diarrhea?			Stools have an unusual color or odor? If yes, explain:	☐	☐
Recent changes in bowel habits?	☐	☐	Any blood or mucous in stool?	☐	☐
Recent changes in appetite?	☐	☐	Any abdominal pain or upset stomach?	☐	☐
Any excessive gas or bloating?	☐	☐	Any heartburn? Or Reflux?	☐	☐
Any loss of bowel control?	☐	☐	Any nausea or vomiting?	☐	☐
Do you have hemorrhoids?	☐	☐	Have you had a blood transfusion?	☐	☐
Have you been diagnosed with Irritable Bowel Synd?	☐	☐	Have you had an upper endoscopy? When?	☐	☐
Do you have Inflammatory Bowel Disease?	☐	☐	Have you had a colonoscopy? When?	☐	☐

WEIGHT HISTORY – I have seen Dr Phone# Fax#			
Are you content with your current weight?	☐	☐	If no, what is your ideal weight?
Does your weight fluctuate?	☐	☐	If yes, give highs and lows:
Any family history of weight problems?	☐	☐	If yes, who?
What factors do you feel contribute to your changes in weight if any (nutrition, exercise, hormones, stress, etc.)?			

EARS, EYES, NOSE AND THROAT – I have seen Dr Phone# Fax#					
Please indicate current (C) or past (P) symptoms	**C**	**P**		**C**	**P**
Loss of consciousness	☐	☐	Vertigo or dizziness	☐	☐
Loss of hearing	☐	☐	Ringing or buzzing in ears	☐	☐
Sinus problems	☐	☐	Loss of smell	☐	☐
Chronic congestion or nasal discharge	☐	☐	Ear infections	☐	☐
Frequent sore throats	☐	☐	Difficulty swallowing	☐	☐
Eye glasses or contacts	☐	☐	Loss of vision	☐	☐
Excessive tearing or dry eyes	☐	☐	Double or blurred vision	☐	☐
Light sensitivity	☐	☐	Sores in mouth, lips or gums	☐	☐
Tooth pain	☐	☐	Mercury dental fillings	☐	☐

RESPIRATORY HEALTH – I have seen Dr Phone# Fax#					
Chronic cough	☐	☐	Difficulty breathing	☐	☐
Bronchitis	☐	☐	Asthma or COPD/Emphysema	☐	☐
Tuberculosis or pneumonia Date of last chest x-ray:	☐	☐	Scarring of lungs due to:	☐	☐
Date of BCG vaccination:			Date of last pulmonary function test:		

CARDIOVASCULAR HEALTH – I have seen Dr Phone# Fax#					
Chest pain	☐	☐	Heart palpitations	☐	☐
Heart murmur	☐	☐	Cold extremities	☐	☐
High or low blood pressure	☐	☐	Angina / Chest pain	☐	☐
Heart attack	☐	☐	Congestive Heart Failure (CHF)	☐	☐

ENDOCRINE HEALTH – I have seen Dr			**Phone#** **Fax#**		
Fatigue	□	□	Heat or cold intolerance	□	□
Excessive hunger or thirst	□	□	Fever or excessive sweating	□	□
Hypoglycemia (Low Blood Sugar)	□	□	Diabetes	□	□
Adrenal Fatigue	□	□	Thyroid conditions	□	□

Readiness To Change: Please rate on a scale of 1 (Very Willing) to 5 (Not Willing), how willing you are to

Significantly modify your diet: □ 1 □ 2 □ 3 □ 4 □ 5
Take several nutritional supplements each day: □ 1 □ 2 □ 3 □ 4 □ 5
Keep a detailed record of everything you eat each day: □ 1 □ 2 □ 3 □ 4 □ 5

Modify your lifestyle (work demands, sleep habits): □ 1 □ 2 □ 3 □ 4 □ 5
Engage in regular exercise: □ 1 □ 2 □ 3 □ 4 □ 5
Practice a relaxation technique daily: □ 1 □ 2 □ 3 □ 4 □ 5

How confident are you of your ability to organize and follow through with the above: □ 1 □ 2 □ 3 □ 4 □ 5

How supportive do you think the people in your household will be to you making these changes: □ 1 □ 2 □ 3 □ 4 □ 5

The above information is true to the best of my knowledge.

_____________________________________ X____ Date ____________
(PRINT name / person legally responsible) *(Signature of Patient / Person Legally Responsible)*

If you are interested in a focused initial consultation only
and you would NOT like to discuss your health history, please complete the following:

I___________________________________ understand the doctors of The Fremont Holistic Center will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctors will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns.

____ X____ Date______________
(PRINT name of patient / person legally responsible) *(Signature of Patient / Person Legally Responsible)*

Fremont Holistic Center: Shibuya Integrative Health –
Informed Consent to Naturopathic Treatment and Care

I have had an opportunity to discuss the nature and purpose for naturopathic care and its procedures with the doctor named below and/or other office or clinic personnel. I hereby request and consent to Integrative Medicine as an alternative treatment for my health conditions (or for those of the patient named below, for whom I am legally responsible) as performed by the doctor named below and/or other licensed Doctors of Naturopathic Medicine who may now, or in the future, treat me while employed by, working or associated with, serving as back-up for the Doctor of Naturopathic Medicine named below, whether they work at the clinic or office listed below or any other office or clinic.

Treatments may include, but are not limited to- herbal medicine, homeopathic medicine, lifestyle and nutritional counseling, naturopathic manual therapy, physical therapy, injection therapy, and hormone replacement. I have been informed that in the practice of medicine there are some risks to treatment, including, but not limited to, side effects of medication, allergic reactions, anaphylaxis, fractures, disc injuries, strokes, dislocation, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the doctor's judgment based upon the facts then known, to provide me with any care and procedures considered to be in my best interest during the course of my treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and I agree to the procedures mentioned above. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient OR by patient's representative, if necessary
(e.g. if the patient is a minor or physically or legally incapacitated).

Print Name: ________________________________ Signed: _____________________________________ Date:_________________

If applicable:

____ ____
PRINT Patient's Representative's Name & Relationship (if applicable) Signature of Patient's Representative:

Date Signed: ______________________

Name of Doctor treating this patient: **Dr. Barry Shibuya, MD, ABIHM**