





INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER

Dear Patient,

We would like to thank you for your confidence in and support of our clinic, and the emerging field of integrative healthcare. It is your support and commitment that has allowed us to flourish and to provide you and our community with the highest quality integrative healthcare. We hope that Manakai O Malama will continue to be your partner in health for years to come.

We are always looking at ways to improve our performance and we welcome your feedback as a way to direct our efforts. Please direct any feedback you have to our customer service email: [customerservice@manakaionalama.com](mailto:customerservice@manakaionalama.com)

We would like to take this opportunity to review our cancellation policy. Your visits are a crucial part of your treatment plan and recovery process. Your individual treatment plan is also designed for your maximum benefit. By missing an appointment or by arriving late and reducing your treatment time you may interrupt the healing process. We do understand that the unexpected happens, and that injury or illness may cause forgetfulness, 'bad days,' etc. To come in for treatment may be the best antidote for those 'bad days'. We ask for your consideration of the following simple guidelines:

**Late Arrival** - Please call if you expect to arrive more than 10 minutes late for an appointment. Our practitioners will do their best to accommodate you if they can do so without disrupting another patients' care. If you are more than 15 minutes late your appointment may be rescheduled and you may be charged a missed appointment fee.

**Initial** \_\_\_\_\_

**Appointment Cancellations** - If you need to cancel an appointment, please give us 48 hours' notice. This allows us to reassign that time slot and reschedule your treatment as needed. Appointments rescheduled within 48 hours may be subject to a **reschedule fee of \$25**. **Initial** \_\_\_\_\_

**Missed Appointments** - If you miss 3 appointments without cause or notification we do reserve the right to suspend your treatment. If you do not show up for a scheduled appointment you may be charged a **\$50 missed appointment fee** for the visit.

**Initial** \_\_\_\_\_

By abiding by these guidelines you can help us maximize our efficiency and your service delivery. On our part, we will continue to make every effort to stay on schedule, to ensure wait times are short, and to offer you the highest quality healthcare.

Mahalo from all of us at Manakai 'O Malama.

*I have read the above and agree to make every effort to abide by these guidelines in the future.*

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

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



HAWAII PRIVACY OF HEALTH CARE INFORMATION LAW  
INTEGRATIVE HEALTHCARE GROUP & REHABILITATION CENTER

In accordance with the American Medical Association Code of Ethics, we believe that the patient-physician relationship is based on trust and confidentiality of communication. The free and uninhibited disclosures of personal information within this relationship are the cornerstone of good medical care.

The privacy of your medical records is of the utmost importance to our staff and us. We have therefore taken measures to ensure that your medical records receive the highest level of confidentiality and security. This office adheres to the following procedures to ensure protection of your private medical records.

- Our office staff has received education and training regarding the use and handling of patients protected health information.
- Your records are secured in this office.
- Access to office keys is limited to our doctors, staff, and bonded cleaning crew.
- Access to electronic information is only released as required or permitted by state or federal law.

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

\_\_\_\_\_, hereby authorize Manakai O Malama Integrative  
(Patient, parent or legal guardian)

Healthcare Group to disclose health information, including copies or summaries of medical records for  
\_\_\_\_\_ to:  
(Name of patient)

- Any health insurance plan or company that provides insurance coverage for the purpose of payment of charges,
- Any insurance company that provides liability insurance coverage for Ira Zunin, MD, Christopher Acree, PA for the purpose of evaluating the treatment rendered or
- Any health care provider that has referred the patient to this office for care, for the purposes of coordination of medical care.

This authorization shall cover the period of time from my first visit to my last visit. I understand that I can revoke this authorization at any time. This authorization shall end two years after the date of my last visit.

\_\_\_\_\_  
Signature Date

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**MEDICAL INFORMATION RELEASE**

I hereby authorize the staff of Manakai O Malama to release my confidential medical information to the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_  
Signature Date

# Pre-appointment Questionnaire

**What is the main reason for your appointment today?**

**Is this due to (circle one):**  Auto Accident  Work Injury  Other Cause  Unknown  Illness

**Are your symptoms:**  Improving  Getting Worse  Staying the Same  Come and Goes

**Activities that aggravate:**  Standing  Walking  Sitting  Lying  Bending  Lifting  Twisting  
 Coughing  \_\_\_\_\_

**Have you seen another health care provider for this problem?**  No  Yes \_\_\_\_\_

When: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**Is there anything you would like to work on to improve your health?**

**Please respond if you have one of the following conditions:**

High Cholesterol	Problems with medication(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Diabetes	Problems with medication(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Most recent home glucose readings:
High Blood Pressure	Problems with medication(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Most recent home blood pressure readings:
Depression	Problems with medication(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A Any suicidal thoughts? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A

**Have you been to the emergency room, hospital or any other provider since your last visit?**

If yes, please explain:

**Have you been diagnosed with any of the following since your last visit?**

If yes, please check:

<input type="checkbox"/> Cardiac Murmurs	<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Mitral Valve disorder
<input type="checkbox"/> Tricuspid valve disorder	<input type="checkbox"/> Pulmonary valve disorder	<input type="checkbox"/> Atrial-Fib	<input type="checkbox"/> Atrial-Flutter
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Cardiomegaly		

**Are you experiencing any of the following?**

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> Runny nose
<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Sleep disturbance*	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Malaise/Fatigue*	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Eye Redness
<input type="checkbox"/> Double vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Swallowing pain	<input type="checkbox"/> Chest Pain*
<input type="checkbox"/> Palpitations*	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Swelling/Edema	<input type="checkbox"/> Pain in Limb *
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Breathing discomfort	<input type="checkbox"/> Blood in sputum
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea/ Vomiting	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Bloating	<input type="checkbox"/> Black/Bloody stool	<input type="checkbox"/> Loose stool	<input type="checkbox"/> Constipation
<input type="checkbox"/> Pain w/ urination	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent/Urgent urination
<input type="checkbox"/> Impotence	<input type="checkbox"/> Irregular menses	<input type="checkbox"/> Neck pain/stiffness	<input type="checkbox"/> Back pain
<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Muscle Stiffness	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Bruising	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Rash	<input type="checkbox"/> Boils
<input type="checkbox"/> Lesions/Moles	<input type="checkbox"/> Changing mole(s)	<input type="checkbox"/> Sun Sensitivity	<input type="checkbox"/> Tingling
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Falling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Fainting
<input type="checkbox"/> Heat/cold Intolerance	<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Weakness	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fear	<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Suicidal Thoughts

**Lifestyle**

**Alcohol**

How often do you have a drink containing alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times per month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times per week
How often do you have six or more drinks on one occasion? <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily

**Caffeine**

Do you consume any caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes: How often?	How much?
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**Exercise**

Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes: How often?	How long?
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**Smoking**

Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes: How often?	How much?
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**Birth control**

Do you use any form of birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes: What method?
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**Medication adherence**

Do you have trouble taking any of your medications? <input type="checkbox"/> No <input type="checkbox"/> Yes: Describe.
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**Are there any changes to your family medical history?** For example, if a family member has received a new diagnosis, we can update your family history to reflect any changes since your last visit.

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**Have you recently developed an allergy to any of your medications?** If yes, please describe below.

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**Do you have any end-of-life care plans or preferences?** If yes, please bring a copy of relevant documents to your upcoming visit (e.g., your advance directive, power of attorney and health care proxy). If not, would you like to discuss your preferences?

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**Disease Prevention Screening:**  
**Sleep Apnea**

Has anyone told you that you snore loudly or stop breathing when asleep?  No  Snoring loudly (heard from another room)  Stop Breathing

**Skin Cancer**

When did you last have a full-body skin cancer check by a medical professional?  I don't know  
 Month/Year\_\_\_\_\_

**Colon Cancer- Adults over 50**

Have you had a colonoscopy or other colon cancer screening?  No  Yes: When?

**Women**

When was your last PAP smear?  I don't know  Month/Year\_\_\_\_\_

**Women Over 40**

Have you had a mammogram?  No  Month/Year\_\_\_\_\_

**Women Over 65**

Have you had a bone density test?  No  Month/Year\_\_\_\_\_

**Diabetes Management:**

When did you last have your diabetic bloodwork done?  I don't know  Month/Year\_\_\_\_\_

When did you last visit your eye doctor?  Never  I don't know  Month/Year\_\_\_\_\_

When did you last visit your podiatrist?  Never  I don't know  Month/Year\_\_\_\_\_

**Do you have any other concerns?** If yes, please describe below.