



# Central Oregon Acupuncture

## How to prepare for your appointment:

- \* Wear loose clothing that can be rolled up on the legs and arms
- \* Because many of our patients are sensitive to perfumes, lotions and scented beauty products, please refrain from using these products on the day of your appointment.
- \* Please have your paperwork filled out and ready by the time of your appointment or come in 10-15 minutes before your appointment to fill it out.
- \* Please make sure that you bring in all of your insurance information:
  - Current Insurance card
  - For accident claims (workers compensation/auto accident):
    - Prescription from you primary doctor for acupuncture
    - Claim #
    - Date of injury
    - Insurance company and contact information
    - Adjuster's name and contact information

**If you can not make it to your appointment,  
we ask that you please give 24 hours notice.  
(541) 330-8298**

# Health History Questionnaire

## *Information for your acupuncturist*

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosing and treatment.  
*All information is strictly confidential.*

### **I. General Patient Information**

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Guardian (If under 18): \_\_\_\_\_

Gender: M  F  Height: \_\_\_' \_\_\_" Weight: \_\_\_\_\_ lbs.

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about us? Walk By  Website  Insurance Company  Phonebook

Referral  Please tell us who referred you, so that we may thank them: \_\_\_\_\_

Other physicians/therapists seen for this condition: \_\_\_\_\_

Medications (if any): \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Supplements (if any vitamins, herbs, minerals, etc.): \_\_\_\_\_

**Major Complaint(s)** (why you are seeking acupuncture), in order of significance to you:

- |    | Severe                   | Moderate                 | Slight                   | Normal                   |       |
|----|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

How do these conditions impair your daily activities? \_\_\_\_\_

**II. Patient Medical History**

How was your childhood health? \_\_\_\_\_

Hospital Visits/Stays: \_\_\_\_\_

Recent Tests: (Please indicate test results and date below)

- Physical                       Cholesterol                       Prostate                       Blood (which?)
- HIV/STD                       Pap Smear                       Mammography                       Other

Test results and date: \_\_\_\_\_

**Check any you have had in the past:**

- Diabetes                       Allergies                       Glaucoma                       Rheumatic Fever
- Heart Attack                       CVA (Stroke)                       Vein Condition                       Thyroid disorder
- Asthma                       Pneumonia                       Tuberculosis                       Emphysema
- Jaundice                       Gonorrhea                       Mumps                       Bleeding tendency
- Syphilis                       Measles                       Chicken Pox                       Nervous disorder
- Meningitis                       HIV                       Polio                       Mononucleosis
- Epilepsy                       High Fever                       Hepatitis                       Multiple Sclerosis
- Paralysis                       Cancer                       Migraines                       High blood Pressure
- Other lung illness                       Other Liver Illness                       Other heart illness
- Other spleen illness                       Other stomach illness                       Other kidney illness
- Other: \_\_\_\_\_

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

**III. Family History**

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
Children	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	

Where were you in the birth order? First  Last  Middle  Only

Check the following that have occurred in your blood relatives:

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Bleeding Tendency   |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental Illness      |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Other: _____ |  |  |

**IV. Patient Profile**

Is the pain:

- |                                |                                       |                                 |                                   |                               |                                 |
|--------------------------------|---------------------------------------|---------------------------------|-----------------------------------|-------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching | <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ |                                 |                                   |                               |                                 |

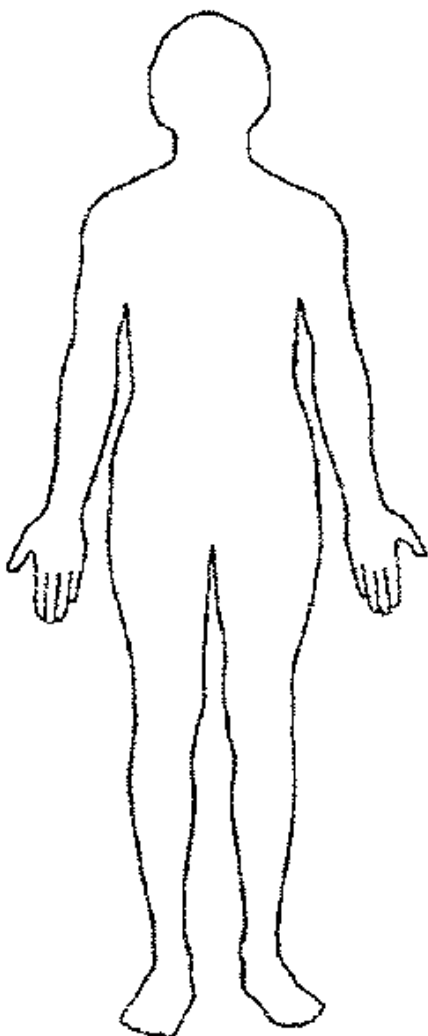
Do the following lessen the pain?

- |                                   |                               |                               |                                   |                                       |
|-----------------------------------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ |
|-----------------------------------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------------|

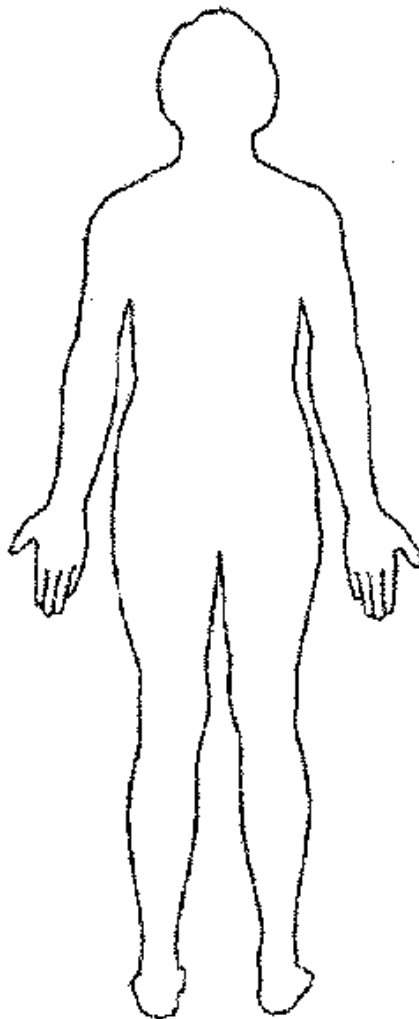
Do the following worsen the pain?

- |                                   |                               |                               |                                       |
|-----------------------------------|-------------------------------|-------------------------------|---------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Other: _____ |
|-----------------------------------|-------------------------------|-------------------------------|---------------------------------------|

Please clearly mark any areas of pain and scars (Please indicate which of the areas are scars):



Front



Back

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**Please check the following that pertain to you:**

**Overall Temperature (Kidney Function):**

- Cold Hands     Hot Body Temperature     Cold Feet     Cold Body Temperature
- Sweaty Hands     Sweaty Feet     Thirsty     Heat in hands, feet, chest
- Night Sweats     Afternoon Flushes     Perspire Easily     Lack of Perspiration
- Take water to bed     Hot Flashes any time of day
- Difficulty keeping eyes open in the daytime

**Overall Energy (Lung, Kidney Function):**

- Shortness of breath     General weakness     Easily catch colds     Low energy
- Feel worse after exercise     Difficulty keeping eyes open in the daytime

**Blood (Liver, Spleen, Heart Function):**

- Dizziness     See floating black spots

**Heart Function:**

- Palpitations     Anxiety     Frequent dreams     Mental Confusion
- Restlessness     Chest pain traveling to shoulder     Wake unrefreshed
- Drink coffee (# of cups per week: \_\_\_\_\_)

**Lung Function:**

- Cough     Nose bleeds     Sinus congestion     Dry Mouth     Stiff neck
- Dry throat     Dry nose     Dry skin     Sneezing     Sore throat
- Difficulty breathing     Stiff shoulders     Melancholy     Sadness
- Alternating fever and chills     Overall achy feeling in body
- Nasal Discharge (Color: \_\_\_\_\_)
- Headache (Location: \_\_\_\_\_)
- Smoke cigarettes (# of cigarettes per day: \_\_\_\_\_)
- Allergies (To what? \_\_\_\_\_)

**Spleen Function:**

- Low appetite     Abrupt weight gain     Abrupt weight loss     Abdominal bloating
- Abdominal gas     Fatigue after eating     Easily bruise     Hemorrhoids
- Pensive     Over-thinking     Gurgling stomach     Worry
- Prolapsed organs(Previously diagnosed, which organ? \_\_\_\_\_)

**Spleen, Stomach, Large Intestine, Small Intestine Function:**

- Loose     Constipated     Incomplete     Diarrhea     Blood in stools
- Mucous in stools     Undigested food in stools

**Dampness trapped in the body:**

- Mental Heaviness     Mental sluggishness     Mental fogginess     Swollen hands
- Swollen feet     Swollen joints     Chest congestion     Nausea
- Snoring     General sensation of heaviness in body



Do you experience any of the following pre-menstrual syndromes?

- Nausea                       Food cravings                       Depression                       Vomiting  
 Headaches                       Irritability                       Water retention                       Migraines  
 Anxiety                       Breast swelling                       Breast tenderness  
 Other emotions: \_\_\_\_\_                       Dull pain, where? \_\_\_\_\_  
 Sharp pain, where? \_\_\_\_\_  
 Other: \_\_\_\_\_

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>Color</b> (Normal, bright red, pale, brown, dark, purple)							
<b>Amount of flow</b> (Normal, heavy, Light)							
<b>Pain/Cramps</b> (Location, dull, sharp)							
<b>Clots</b> (Large, small, black, purple, red)							
<b>Vomiting</b> (check if yes)							
<b>Nausea</b> (check if yes)							
<b>Other</b>							

**Men Only:**

- Swollen testes                      Severe                       Moderate                       Slight                       Normal   
 Testicular pain                      Severe                       Moderate                       Slight                       Normal   
 Premature ejaculation                      Severe                       Moderate                       Slight                       Normal   
 Feeling of coldness or numbness in external genitalia                      Severe                       Moderate                       Slight                       Normal   
 Other: \_\_\_\_\_

Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Informed Consent to Treatment

Oriental Medicine is an ancient form of healing that began in China over 3,000 years ago and is now utilized throughout the world. Diagnosis and treatment are based on the premise that our bodies run on bioelectrical energy called Qi (“chee”) that runs through our systems in organized energy flows called meridians. This energy can be affected by both internal and external factors, such as extreme emotions, seasonal and environmental changes, trauma, and can create imbalances in the system that can lead to physical and psychological manifestations. Oriental Medicine takes into account the incredible complexity of each individual’s mind, body, and spirit. The goal of treatment is to rebalance the energetic systems, optimizing a person’s function on all levels.

Oriental medicine is a proven, safe, and effective form of treatment for a wide variety of conditions and can work well in conjunction with any other medical treatment with no side effects. The primary modality used in Oriental Medicine is acupuncture, the insertion of thin, sterile, single-use disposable needles in the body. Various sensations are experienced during treatment including a distended feeling around the needle site, itching, tingling, a dull ache, or energy moving. Some patients feel nothing until after the treatment. If at any time you experience a stinging, burning or any uncomfortable feeling please let your practitioner know so the needle may be adjusted or removed. After the needles are in place you will be given time to rest, usually 20-45 minutes. During this time many experience a floating or heavy sensation, but typically feel comfortable, relaxed and sometimes fall asleep. It is advisable to avoid heavy exercise, eating, alcohol, or stimulants just before or after treatments. Please inform your acupuncturist if you have any food or drug allergies, if you are pregnant, or wearing a pacemaker.

Inherent risks of acupuncture treatment include and are not limited to slight bruising and dizziness. It is possible to experience changes in emotions, appetite, sleep, energy levels, and bowel or urinary patterns. If you have any concerns, do not hesitate to call in a medical emergency contact your physician or nearest medical facility.

**Cancellation policy:** Please give at least 24 hours notice if you need to reschedule so that the time may be used for someone else. If notice is not given, you may be charged a cancellation fee for the missed appointment.

I, (patient/guardian) \_\_\_\_\_ do hereby request and consent to the performance of procedures that are within the scope of Acupuncture and Oriental Medicine as recognized by the state of Oregon, including but not limited to: acupuncture, moxibustion, cupping, electro-acupuncture, herbal therapy, nutritional consultation, and infra-red heat therapy on me (or the patient for whom I’m legally responsible), by the licensed acupuncturists who now or in the future work with me. I have the choice at any time to accept or reject any procedure being offered, and understand that the results are not guaranteed.

This consent is intended to cover the entire course of treatment for any present conditions and for any future conditions for which I seek treatment. I am responsible for all payments of my treatments at the time of service. My signature below signifies that I have read and understand all of the above, all privacy practices and cancellation policies, and I give my consent to treatment.

\_\_\_\_\_  
*Signature of Patient or Legal Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print the patient’s name here  
(If you are not the patient)*

**Jennifer L. Cochrane, L.Ac.**  
**State License # AC00648**  
P. (541) 330-8298 F. (541) 317-9569

**INSURANCE INFORMATION**

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy/ ID# : \_\_\_\_\_ Group #: \_\_\_\_\_

Do you have an open accident claim? Yes  NO

**Accident Information:**

Date of accident: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_

Your primary/referring doctor: \_\_\_\_\_

*Accident claims: You must have a prescription for acupuncture from your primary doctor prior to your first appointment.*

**PAYMENT**

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, and any services rejected by my insurance company. I understand that benefits quoted to Central Oregon Acupuncture by my insurance company are not a guarantee of payment and that I am ultimately responsible for all charges incurred.

**RELEASE OF INFORMATION**

I also authorize this office to release any information that is required or necessary for my claim to an insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequences thereof.

**ASSIGNMENT**

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this office, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for service rendered by this office. I give this office power of attorney to endorse checks made out to me, to be credited to my account.

\_\_\_\_\_  
*Signature of Patient or Legal Guardian*

\_\_\_\_\_  
*Date*

**OFFICE USE ONLY**

**Today's Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Insurance Co. Rep. Talked to:** \_\_\_\_\_

**Co-pay:** \_\_\_\_\_ **Paid at (%):** \_\_\_\_\_

**Deductible:** \_\_\_\_\_ **Met:** \_\_\_\_\_ **Max:** \_\_\_\_\_ **Used:** \_\_\_\_\_

**Notes:** \_\_\_\_\_