



# 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: \_\_\_\_\_

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

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

Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

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

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

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

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_

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

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

Phonebook  If phonebook, which brand? \_\_\_\_\_

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"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	<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)

- |                                   |                                      |                                      |   |
|-----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate    | <input type="checkbox"/> Blood (which?) |
| <input type="checkbox"/> HIV/STD  | <input type="checkbox"/> Pap Smear   | <input type="checkbox"/> Mammography | <input type="checkbox"/> Other          |

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

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

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

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

##### Is the pain:

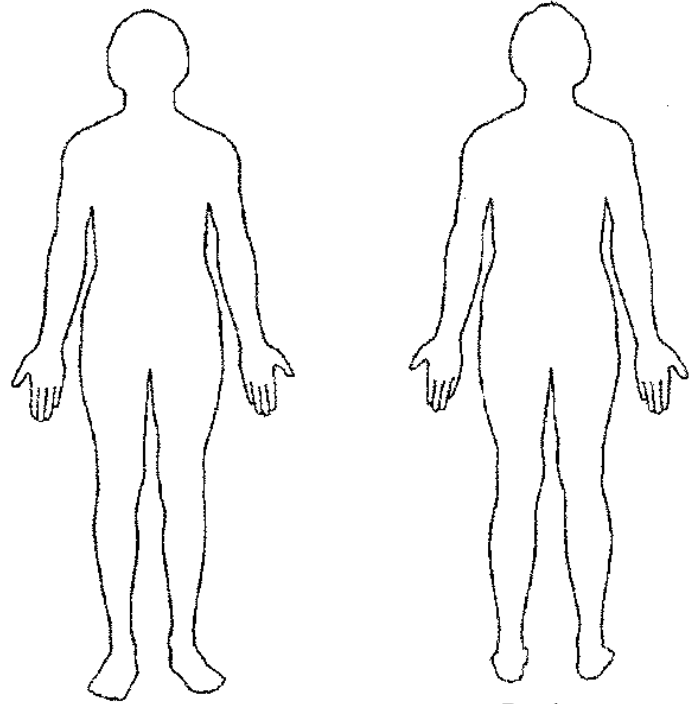
- Sharp       Burning       Aching
- Cramping       Dull       Moving
- Fixed       Other: \_\_\_\_\_

##### Do the following lessen the pain?

- Pressure       Cold       Heat
- Exercise       Other: \_\_\_\_\_

##### Do the following worsen the pain?

- Pressure       Cold       Heat
- Other: \_\_\_\_\_



Front

Back

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

##### Overall Temperature (Kidney Function):

- Cold Hands       Hot Body Temperature
- Cold Feet       Cold Body Temperature
- Sweaty Hands       Heat in hands, feet, chest
- Sweaty Feet       Thirsty
- Afternoon Flushes       Perspire Easily
- Night Sweats       Lack of Perspiration
- Hot Flashes any time of day
- Take water to bed
- 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: \_\_\_\_\_)

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**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

**Stomach Function:**

- Large appetite       Bad breath       Heartburn       Mouth (canker) sores
- Belching       Acid regurgitation       Hiccoughs       Ulcer (diagnosed)
- Stomach pain       Vomiting       Burning sensation after eating
- Bleeding, swollen or painful gums

**Liver, Gall Bladder Function:**

- Chest pain       Anger easily       Frustration       Alternating diarrhea & constipation
- Depression       Irritability       Skin rashes       Tight sensation in the chest
- Numbness       Muscle spasm       Muscle twitch       Bitter taste in the mouth
- Seizures       Muscle cramp       Convulsions       Headache at the top of the head
- Limited range of motion, neck       Lump in the throat
- Limited range of motion, shoulder       Shoulder Tension
- High- pitched ringing in ears       Neck tension
- Gall stones (history or current)       Tingling sensation
- Frequently unable to adapt to stress (what causes stress? \_\_\_\_\_)
- Drink alcohol       Recreational drugs (which? \_\_\_\_\_, times per week \_\_\_\_\_)
- Sexually transmitted disease (which? \_\_\_\_\_)

**Eyes (Liver Function):**

- Itchy                       Bloodshot                       Hot                       Blurred vision
- Watery                       Gritty                       Dry                       Decreased night vision
- Near-sighted               Far-sighted

**Kidney, Urinary Bladder Function:**

- Frequent cavities       Sore knees                       Weak knees               Cold sensation in knees
- Low back pain               Memory problems       Kidney stones               Easily broken bones
- Bladder Infections       Excessive hair loss       Fear                       Easily startled
- Low-pitched ringing in ears                       Lack of bladder control
- Wake during night twice or more to urinate

**Urination:**

- Normal color               Dark yellow                       Clear                       Reddish
- Cloudy                       Scanty                       Profuse                       Strong odor
- Burning                       Painful                       Discharge                       Difficult
- Urgent                       Frequent

**Libido:**

- Normal                       High                       Low

**Other Symptoms:**

**Women Only:**

- Regular menstrual cycle? Yes  No                       Pregnant? Yes  No
- # of children: \_\_\_\_\_                      # of pregnancies: \_\_\_\_\_
- Age at 1<sup>st</sup> menstruation: \_\_\_\_\_                      Age at menopause: \_\_\_\_\_
- Average # of days of flow: \_\_\_\_\_                      Average # days of entire cycle: \_\_\_\_\_
- Vaginal discharge:                      Severe                       Moderate                       Slight                       Normal
- Bleeding between periods:                      Severe                       Moderate                       Slight                       Normal

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: \_\_\_\_\_

**All please fill out:**

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

Patient Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## **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**  
222 SE Urania Ln. Bend, OR 97702  
P. (541) 330-8298 F. (541) 3179569

**INSURANCE INFORMATION**

Insured Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
Patient Social Security #: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Address (Back of Card): \_\_\_\_\_  
City: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy/ ID# : \_\_\_\_\_ Group #: \_\_\_\_\_

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

1. Authorization:

I authorize Central Oregon Acupuncture, LLC to use and disclose the protected health information described below to \_\_\_\_\_  
(Physician/Medical office).

2. Effective Period:

This authorization for release of information covers the period of healthcare from:

a.  \_\_\_\_\_ to \_\_\_\_\_.

**OR**

b.  all past, present, and future periods.

3. Extent of Authorization:

a.  I authorize the release of my complete health record (including records relation to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR**

b.  I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment and consultation, or other purposes as I may direct.

