

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: _____

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:

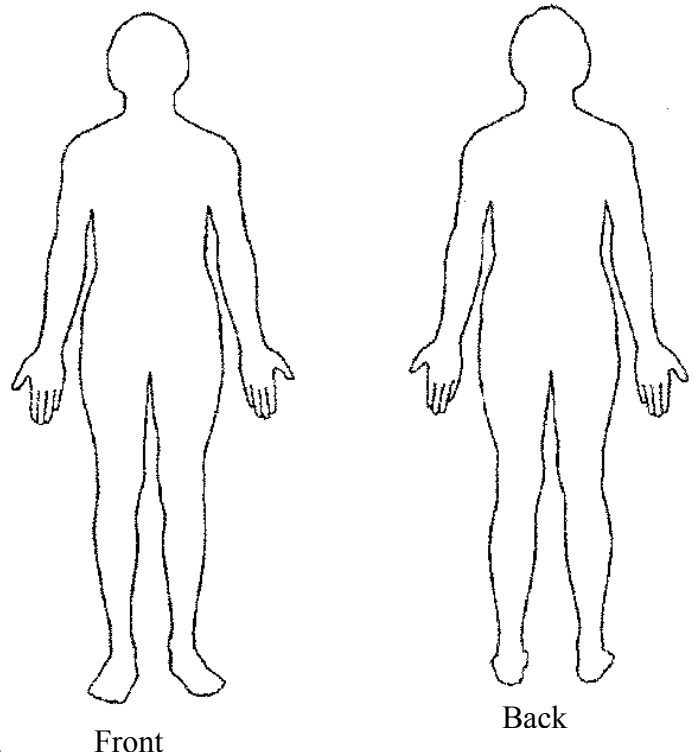
- Sharp Burning Aching
- Cramping Dull Moving
- Fixed Other: _____

Do the following lessen the pain?

- Pressure Cold Heat
- Exercise Other: _____

Do the following worsen the pain?

- Pressure Cold Heat
- Other: _____



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: _____)

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 foginess 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 1st 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
Color (Normal, bright red, pale, brown, dark, purple)							
Amount of flow (Normal, heavy, Light)							
Pain/Cramps (Location, dull, sharp)							
Clots (Large, small, black, purple, red)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

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. You or your insurance company may be charged for an appointment that is cancelled within the 24 hour period.

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)*

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INSURANCE INFORMATION

Insured Name: _____ Patient Name: _____
Insured's Date of Birth: _____ Patient's Date of Birth: _____
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: _____