Balanced Garden Acupuncture
Matthew Truhan, MSTOM, Dipl.O.M., L.Ac.
1693 SW Chandler Ave #280, Bend, OR 97702
541-318-1000

This is a CONFIDENTIAL questionnaire to determine the best treatment plan for you. If you have any questions, please feel free to ask the practitioner.

Name:_____ Birthdate: ____/____/____ Age:_____

Home Address: _____

City, State, Zip: _____

Phone – Home:_____ Cell/Carrier:_____ Email: _____

Emergency Contact/Relationship: _____ Phone#: _____

Primary Care Physician: _____

Who can we thank for your referral? How did you hear of us?_____

Have you had Acupuncture before? Yes No When? _____ With whom? _____

Sex: ❑Male ❑Female ❑Trans Height: _____ Weight: _____

Marital Status: ❑Single ❑Married ❑Partner ❑Widowed ❑Divorced Number of Children:_____

Personal/Family Medical History

Please indicate any illnesses you or a blood relative(**M**other, **F**ather, **S**ibling, **G**rand**M**other, **G**rand**F**ather) have had:

	You	Relative	Date		You	Relative	Date
Cancer	❑			Hepatitis	❑		
Diabetes	❑			Thyroid Imbalance	❑		
Seizures	❑			Auto Immune	❑		
Heart Disease	❑			Ulcer	❑		
High/Low Blood Pressure	❑			Eating Disorder	❑		
Blood Clotting Disorder	❑			Alcohol/Drug Addiction	❑		
Anemia	❑			Chronic Fatigue	❑		
Stroke	❑			Chronic Pain	❑		
Alzheimers	❑			Emotional Disorder	❑		
Kidney Disease	❑						

Sexually Transmitted Diseases: ❑Gonorrhea ❑Syphilis ❑Chlamydia ❑HIV ❑HPV ❑Herpes Date: _____

Check box for any true statements: ❑I have a pacemaker ❑I have known allergies
❑I am taking Coumadin/Warfarin ❑I am taking Lithium

Medications (Herbs/Vitamins/Supplements)

Check each that you currently use :

❑Laxatives ❑Antibiotics ❑Sleeping Pills
❑Pain Relievers ❑Heart/Blood medication ❑Anti-Depressants
❑Antacids ❑Allergy Medication ❑Birth Control Pills
❑Cortisone ❑Thyroid medication ❑Hormones

List any medications, supplements, or herbs (prescribed or Over the Counter) you are currently taking:

Medicine	Dosage	Reason	Prescribed by	Started	Last check-up

Please indicate the use and frequency of: ❑Cigarettes_____ ❑ Recreational Drugs_____

Allergies: Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances? _____

Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies

Please include accidents, falls, illness as well as emotional along with month/year

Exercise, Energy and Dietary

How much exercise per week?_____Length of workout _____Activities _____

How is your energy level? _____When is it lowest? _____Highest? _____

Typical Diet

Are you on a special diet: _____

Meals per day _____ # of Snacks _____

Please give an example of your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What foods are your weakness? _____

What is your daily or weekly intake of: Water: _____ Soda: _____

Coffee: _____ Tea: _____ Alcohol: _____

Do you prefer your drinks ❑Warm or ❑Cold? Do you feel your thirst to be ❑excessive or ❑insufficient?

Which of the following symptoms do you experience? Indicate if occurrence is frequent (F) or occasional (O).

Tendency to faint easily	F	O
High blood pressure	F	O
Sudden weight loss	F	O
Changes in moles/lumps	F	O
Weight gain (sudden)	F	O
Bloody stools	F	O
Black/tarry stools	F	O
Fatigue	F	O
Stress	F	O
Depression	F	O
Anxiety or anxiety attacks	F	O
Edema	F	O
Persistent cough	F	O
Shortness of breath	F	O
Decreased sense of smell	F	O
Nasal problems	F	O
Bronchitis	F	O
Asthma	F	O
Hay fever/airborne allergy	F	O
Skin problems	F	O
Dry/Itchy skin	F	O
Perspires easily or heavily	F	O
Claustrophobia	F	O
Catch colds easily	F	O
Intolerant to weather changes	F	O
Pain/Pressure in chest	F	O
Palpitations	F	O
Insomnia	F	O
Nightmares	F	O
Mental restlessness	F	O
Easily frightened	F	O

Eye problems (dry, itchy)	F	O
Jaundice	F	O
Hepatitis/Liver disease	F	O
Difficulty digesting oily food	F	O
Gall stones	F	O
Light colored stools	F	O
Soft or brittle nails	F	O
Muscle spasm or twitches	F	O
Easily angered or agitated	F	O
Food intolerances/ Allergies	F	O
Excessive or low appetite	F	O
Digestion problems	F	O
Feeling of food retention	F	O
Bloating or Gas	F	O
Belching or burping	F	O
Vomiting/Nausea	F	O
Heartburn	F	O
Stomach pain/cramps	F	O
Constipation	F	O
Loose stools or diarrhea	F	O
Hemorrhoids	F	O
Organ prolapse	F	O
Easily bruised	F	O
Tend to obsessive thought	F	O
Low back pain	F	O
Sciatica	F	O
Knee problems	F	O
Hearing impairment	F	O
Ringing in the ears	F	O

Kidney stones	F	O
Decreased sex drive	F	O
Feels warmer than others	F	O
Feels colder than others	F	O
Hair loss	F	O
Urinary problems	F	O
Pain/burning on urinating	F	O
FEMALES:		
Menstrual pain	F	O
Irregular periods	F	O
Heavy bleeding	F	O
Pre-menstrual syndrome	F	O
Yeast infections	F	O
Vaginal Discharge	F	O
Vaginal Itching/Burning	F	O
Vaginal Odor	F	O
Hot flashes	F	O
Breast Pain / Tenderness	F	O
Nipple Discharge	F	O
Breast Lumps	F	O
Pelvic Adhesions/Scarring	F	O
MALES:		
Impotence	F	O
Premature ejaculation	F	O
Prostate problems	F	O
Hernias	F	O
Testicular Masses	F	O
Testicular Pain	F	O
Varicoceles	F	O
Discharge or Sores	F	O

How do you feel about the following areas?

	Great	Good	Fair	Poor	Bad	Comments
Self	❑	❑	❑	❑	❑	
Sig. other	❑	❑	❑	❑	❑	
Family	❑	❑	❑	❑	❑	
Work	❑	❑	❑	❑	❑	
Diet	❑	❑	❑	❑	❑	
Exercise	❑	❑	❑	❑	❑	
Sex	❑	❑	❑	❑	❑	
Spirituality	❑	❑	❑	❑	❑	

OBGYN

Are you pregnant? ❑Yes ❑No # of Pregnancies _____Live Births_____Abortions_____Miscarriages_____

Date of: Last exam _____ Pap Smear _____Mammogram_____Bone Density_____

Results: _____

Age of first menses: _____ If menopause/post-menopause, age of last menses: _____

Date of last menses: _____ Recent menstrual changes; if so, what? _____

How many days do you normally bleed? _____ How many days between periods? _____
How heavy is the bleeding? ❑Heavy ❑Medium ❑Light

Average # of pads/tampons used on: Day 1 _____Day 2 _____Day 3 _____Day 4 _____Day + _____
What color is the blood usually? ❑Pale red ❑pink red ❑dark red ❑purple ❑brown ❑black
Is the blood usually (check all that apply): ❑Watery ❑Mucousy ❑Thin ❑Thick ❑Strong odor

Clots: ❑No ❑Yes; Color: _____ Size: _____
Have you been diagnosed with ❑Fibroids ❑Fibrocystic Breast ❑Endometriosis ❑PID
❑Ovarian Cysts/Polycystic Ovarian Syndrome ❑Pelvic Adhesions

Painful periods: Location ❑Abdomen ❑Thighs ❑Back ❑Other _____
Nature of pain (Please indicate **B**efore, **D**uring, or **A**fter menses)
Aching _____ Cramping _____ Dull _____ Stabbing _____ Burning _____
Bloating _____ ❑Intermittent ❑Constant ❑Bearing down sensation

Other symptoms related to menses:

❑Mood swings	❑Nausea	❑Constipation
❑Discharge	❑Poor appetite	❑Diarrhea
❑Vaginal dryness	❑Ravenous appetite	❑Hot flashes
❑Swollen breasts	❑Increased libido	❑Night sweats
❑Headache	❑Decreased libido	❑Insomnia

Urogenital

Date of last prostate check _____PSA results _____Manual exam results_____

Frequency of Urination: daytime _____Night_____Color: ❑Clear ❑Murky ❑Odor: _____
Symptoms related to prostate:

❑Delayed Stream	❑Retention of urine	❑Premature ejaculation	❑Testicular pain
❑Post Void Dribbling	❑Erectile dysfunction	❑Back pain	❑BPH/Enlarged prostate
❑Incontinence	❑Increased libido	❑Groin pain	
❑Decreased force	❑Decreased libido		

Because certain medical conditions are contraindicated for treatment, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ _____ _____
Patient Name – Print Patient Name – Signature Date

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Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Chinese Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by licensed acupuncturist, Matthew Truhan.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Print Name of Patient	Date Consent Completed
X_____	X_____
Signature of Patient (or Representative)	Signature of Witness/Translator
_____	_____
Print Name of Representative	Print Name of Witness/Translator

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HIPAA Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer the updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (please print)

_____

Patient or Representative Signature Date

☐ Patient refused to sign

☐ Patient was unable to sign because

_____

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INSURANCE PATIENTS

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submissions on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your frees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. Please note that if Medicare doesn't pay for Exams and Therapies you may have to pay.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Any quote of benefits from your insurance company to us is not a guarantee of payment from them to us. This means that if your insurance states they will cover a treatment, but then deny the claim stating that it is not a covered service, you will be responsible for the payment. We will work with you on a payment plan if that is what would work best for you.

Please make all co-pays and payments at the time of service.

Signature: _____ Date: _____

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Financial Policy

Welcome! To ensure your treatments are as stress free as possible we have established a clear financial policy.

Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!

____ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated

____ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged and additional 35% to cover the cost of collections. (this amount will be added to you bill) *

I have read and understand the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party **Date**

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Cancellation and No Show Policy

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires 24 hours' notice to cancel an appointment. If 24 hours is not given, a charge of $25 will be billed to your account.

If you do not show up for your appointment, you will be responsible for a $25 no show fee.

Patients that cancels 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee.

Inclement Weather Policy

Please be aware of the local forecast and if you feel that you are unable to come in for your scheduled appointment make sure to cancel 24 hours before. The above policies will be applied.

If we close the office due to weather you will receive a phone call from our reception staff and cancellation fee will not be applied.

_____ _____

Signature of Patient or Responsible Party **Date**