Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
Matthew Truhan, L.A.c, Dipl.O.M., MSTOM, 1693 SW Chandler Ave, Suite 280 Bend OR 97702
P: 541-318-1000 F: 541-318-7050

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:________________________Work: ________________________

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?

Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
Matthew Truhan, L.A.c, Dipl.O.M., MSTOM, 1693 SW Chandler Ave, Suite 280 Bend OR 97702
P: 541-318-1000 F: 541-318-7050

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

Symptom		
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

Symptom		
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

Symptom		
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	❑	❑	❑	❑	❑	

Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
Matthew Truhan, L.A.c, Dipl.O.M., MSTOM, 1693 SW Chandler Ave, Suite 280 Bend OR 97702
P: 541-318-1000 F: 541-318-7050

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

Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
1693 SW Chandler Ave, Suite 280 Bend, OR 97702
P: 541-318-1000 F: 541-318-7050

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental 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______________________________ Signature of Patient (or Representative)	X______________________________ Signature of Witness/Translator
______________________________ Print Name of Representative	______________________________ Print Name of Witness/Translator

Wellness Doctor Natural Healthcare and Chiropractic Sports Medicine
1693 SW Chandler Ave, Suite 280 Bend, OR 97702
P: 541-318-1000 F: 541-318-7050

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

____