**COLORADO MANDATORY DISCLOSURE STATEMENT**

**Dr. Tara Ritter, DC, FIAMA**  
Dr. Tara Ritter has an undergraduate degree in Kinesiology and Applied Physiology from the University of Colorado at Boulder (1999) and a Doctor of Chiropractic degree from Northwestern Health Sciences University (2005).  She received her Acupuncture License, as an adjunct to her Chiropractic License in the state of Colorado, in October 2006.  She did her acupuncture fellowship training through The International Academy of Medical Acupuncture Inc. (IAMA), which is an institute of higher learning dedicated to teaching physicians both the ancient as well as contemporary principles of Acupuncture.

**Shawn Sisneros L.Ac., Dipl.OM  MSTOM**

Shawn Sisneros has an undergraduate degree from The School of the Art Institute of Chicago (2001) and a Master's of Science in Traditional Oriental Medicine from Pacific College of Oriental Medicine in Chicago (2015). He was licensed for acupuncture and board certified as an herbalist in the state of Illinois in (2016) and practiced there until August 2018 when he moved to Colorado. He was then licensed in Colorado in (2018). He had over 4000 hours of training in the traditional forms of Acupuncture and Chinese Herbalogy as well as contemporary Western methods of care.

**Financial Awareness and Consent**: I understand that I will be financially responsible for all charges incurred by me, regardless of case type. I understand that initial treatment and consultation fee is $125.00 and any follow up acupuncture treatments are $80.00. I understand that full payment of acupuncture treatment, herbs and Chinese Medicine is due at the time of service. Natural Balance accepts cash, credit/debit cards, and checks. I understand that the fees for herbs and supplements are dependent on the specific herb or supplement.

I understand that there is a 24 hour cancellation policy and I will be charged the full fee for a missed appointment for failure to cancel or reschedule my appointment with 24 hours of my scheduled appointment time.

**Patient’s Rights**

Each patient who visits this clinic is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of Regulatory Agencies in the Department of Regulatory Agencies. The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado, 80202. Telephone: 303-894-7800.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

**Patient’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or legal guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**ACUPUNCTURE INFORMED CONSENT**

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, moxibustion, cupping therapy, allergy elimination technique, and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. It is recommended that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or Coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

**Patient’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or legal guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Acupuncture Patient Information**

Please complete this form as thoroughly as possible. All information is confidential.

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major complaints, in order of importance to you:**

**Complaint #1** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When/how did this condition occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does this condition impair your daily activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatments have you received for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Get temporary relief? \_\_\_\_\_\_\_\_\_ Fixes Problem? \_\_\_\_\_\_\_\_\_\_\_ Causes side Effects? \_\_\_\_\_\_\_\_\_\_\_

**Complaint #2** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When/how did this condition occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does this condition impair your daily activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatments have you received for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Get temporary relief? \_\_\_\_\_\_\_\_\_ Fixes Problem? \_\_\_\_\_\_\_\_\_\_\_ Causes side Effects? \_\_\_\_\_\_\_\_\_\_\_

**Complaint #3** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When/how did this condition occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does this condition impair your daily activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatments have you received for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Get temporary relief? \_\_\_\_\_\_\_\_\_ Fixes Problem? \_\_\_\_\_\_\_\_\_\_\_ Causes side Effects? \_\_\_\_\_\_\_\_\_\_\_

What are your goals for your acupuncture visits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture treatments before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns about having acupuncture? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your commitment to feeling better: 1 2 3 4 5 6 7 8 9 10

**Other Complaints/Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History:** Do you consume or participate in any of the following on a regular basis:

**□ Alcohol**

**□ Tobacco**

**□ Drugs**

**□ Coffee or Tea**

**□ Soft Drinks**

**□ Salt**

**□ Sugar**

**□ Vegetarian Diet**

**□ Consumption of Soy**

**Please List** any serious diseases or illness in your family history such as cancer, diabetes, hypertension, heart disease, etc.

Mother:

Grandparents:

Father:

Siblings:

**Please circle current complaints and check past complaints:**

**Musculoskeletal**

|  |  |  |
| --- | --- | --- |
| Neck Pain | Muscle Pain | Knee Pain |
| Back Pain | Muscle Weakness | Foot/Ankle Pain |
| Hand/Wrist Pain | Muscle Spasms | Hip Pain |
| Elbow Pain | Shoulder Pain | Hernia Pain |
| Brittle Bones | Deformities of Bones | Areas of Numbness/Tingling |
| Joint Swelling | Arm Pain | Rib Pain |
| Leg Cramps | Muscle Atrophy | Other: |

**Neurophysiological/Emotional**

|  |  |  |
| --- | --- | --- |
| Seizures | Dizziness | Loss of Balance |
| Regions of Numbness | Lack of Coordination | Poor Memory/Concentration |
| Head Injury | Loss of Memory | Anxiety |
| Bad Temper | Low Stress Tolerance | Sadness |
| Worry, Over-thinking | Fearful | Weepy |
| Mood Swings | Suicidal | Depression |
| Confusion | Tremors | Paralysis |
| Convulsions | Tics | Mental Illness |

**General**

|  |  |  |
| --- | --- | --- |
| Night Sweats | Insomnia | Fatigue |
| Fevers | Chills | Nightmares |
| Spontaneous Sweating | Hot or Cold Intolerance | Cravings |
| Weakness | Bleed or Bruise Easily | Weight Gain/Loss |
| Psoriasis | Rashes | Eczema |
| Sudden Energy Drop: time? | Hair Loss | Itchy or Dry Skin |
| Sleep too Much | Swollen Glands | Acne |
| Fungal Infections | Dandruff | Ulcerations |
| Dental Amalgams | Symptom Worsen When Tired | Symptoms Worsen With Stress |

**Cardiovascular**

|  |  |  |
| --- | --- | --- |
| High Blood Pressure | Low Blood Pressure | Chest Pain |
| Irregular Heartbeat | Blood Clots | Fainting |
| Swelling of Hands/Feet | Varicose Veins | Rapid Heartbeat/Palpitations |

**Respiratory**

|  |  |  |
| --- | --- | --- |
| Cough | Coughing Blood | Asthma |
| Bronchitis | Pneumonia | Sinus Congestion |
| Difficulty Breathing | Nasal Congestion | Nose Bleeds |
| Catch Colds Frequently/Easily | Production of Phlegm: Color? | Allergies |

**Gastrointestinal**

|  |  |  |
| --- | --- | --- |
| Increased Appetite | Decreased Appetite | Nausea |
| Vomiting | Diarrhea | Constipation |
| Gas | Belching | Loose Stools |
| Black Stools | Rectal Pain | Indigestion |
| Light Stools | Hemorrhoids | Bad Breath |
| Parasutes | Heartburn/Indigestion | Foods Sit in Stomach |
| Itchy Anus | Anal Fissures/Fistula | Hiccup |
| Blood in Stool | Problems Swallowing | Hepatitis |
| Excessive Thirst | Gallstones | Food Allergies |
| Mouth Sores | Peculiar Tastes/Smells | Desire for Hot/Cold Foods |
| Current Weight \_\_\_\_\_\_\_\_\_lbs | Reflux | Hiatal Hernia |

**Genito-Urinary**

|  |  |  |
| --- | --- | --- |
| Pain on Urination/Urinary Tract | Frequent Urination | Blood in Urine |
| Urgency to urinate | Unable to Hold Urine | Kidney Stones |
| Decrease in Flow | Genital Sores | Night Time Urination |
| Dark Urine | Cloudy Urine | Urine smells Strongly |
| Bedwetting | Difficulty Urinating | Edema: Where? |

**Head, Eyes, Ears, and Throat**

|  |  |  |
| --- | --- | --- |
| Fainting | Grinding Teeth | Migraines |
| Headaches | Spots in Front of Eyes/Floaters | Blurry Vision |
| Poor Night Vision | Light Sensitivity | Red/Itchy Eyes |
| Eye Pain | Pressure Behind Eyes | Sores on Lips/Tongue |
| Earaches | Increased Ear Wax | Ringing in Ears |
| Poor Hearing | Ear Pressure | Dizziness |

**Women**

|  |  |  |
| --- | --- | --- |
| Endometriosis | Polycystic Ovarian Disease | Days Between Period |
| Days of Bleeding | Menstrual Blood Color: | Clots |
| Heavy of Light Periods | Irregular or no periods | Menstrual Pain |
| PMS | Number of Pregnancies: | Number of Abortions: |
| Number of Children | Method of Birth Control: | Are you Pregnant? Yes No |
| Difficult Birth/Caesareans | Increased/Decreased Libido | Hot Flashes |
| Vaginal Dryness | Night Sweats | Age Menses Began: |
| Breast Problems | Vaginal Discharge/Sores | Age at Menopause: |
| Date of Last PAP? | Sexually transmitted disease | HPV Positive: Yes No |
| Female Infertility Issues | Infertility | Number of miscarriages |
| Anovulation | Immune Issues like High ANA | Pelvic Inflammatory Disease |
| Used Birth Control Pills or Depo | Tested for Chlamydia? Yes No | # of IUI/IVF Cycles? |
| FSH Levels if Known | Fibroids Adhesions Cysts | Low Progesterone |
| Mastitis | Yeast Infections/Vaginitis | Other: |

**Men**

|  |  |  |
| --- | --- | --- |
| Prostrate Problems | Painful/Swollen Testicles | Discharge From Penis |
| Ejaculation Problems | Impotence | Sexually Transmitted Disease |
| Increased/Decreased Libido | Weak Erection | Varicocele |
| Male Fertility Issues | Testicular Pain/Lump | Immune Issues like Antisperm |
| Undescended Testicles | Sperm Analysis Normal? Yes No | Other: |