Acupuncture Health History Form

RYKEN CHIROPRACTIC & WELLNESS CENTER
290 S. Alma School Rd, Ste 5, Chandler, AZ 85224

Name:		Date:
Email:		Phone:
Date of Birth:	Age:	Occupation:
Address:		Emergency Contact & Phone:

Top 3 things you'd like acupuncture to help you with	Level of severity (10 being most severe)
1.	1 2 3 4 5 6 7 8 9 10
2.	1 2 3 4 5 6 7 8 9 10
3.	1 2 3 4 5 6 7 8 9 10

History of present condition(s)	Average Stress level (10 being most severe)
	1 2 3 4 5 6 7 8 9 10
	How would you describe your diet?
	O American standard
	O Paleo/Keto
Current Medications/Supplements	O Vegetarian/Vegan
	O Inconsistent
	O Other:
List all serious illnesses, accidents & surgeries in the last 5 years	How would you describe your sleep?
	Hours per night/day:
	Quality of sleep:

Check any symptoms that currently apply		
O History of fainting	O Fatigue	O Vomiting
O Dizziness	O Asthma	O Constipation
O Anemia	O Night sweats	O Stomach pain
O Arthritis	O Cough	O Diarrhea
O Diabetes	O Sore throat	O Blood in urine
O Epilepsy	O Fever	O Itching/rash
O Blurred/failing vision	O Headaches	For Women only
O Hearing loss	O Ear ringing: high or low pitch	O Menopausal symptoms
O Low libido	O Chest pain	O PMS
O Cancer	O High blood pressure	O Amenorrhea (no menses)
O Bruise easily	O Low blood pressure	O PCOS
O Tend to feel hot easily	O Indigestion/heartburn	O History of miscarriage
O Tend to feel cold easily	O Nausea	O Possibly pregnant?

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the Acupuncturist. I understand that methods or treatment may include, but are not limited to acupuncture, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method treatment, but occasionally there may be some bruising or tingling neat the needle sites that last a few days. There have been very rare instances reporting of fainting, infection or scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgement during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above-named procedures. 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.

Notice of Privacy Policies

This notice describes our policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. This notice will remain in effect until it is replaced or amended by changes of law.

We gather personal information and health information in several ways: information we receive, information we receive from other healthcare providers and information we receive from third party players.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

This office may use or disclose your Protected Health Information when required by law.

Upon written request, you have the right to access, review or receive copies of your healthcare records. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information. Upon written request you have the right to request that this office place additional restrictions on disclosure of your Protected Health Information. Upon written request you have the right to request that we amend your Protected Health Information. You have the right to receive all notice in writing.

If you have any questions, complaints or want more information, please contact Ryken Wellness Center. At (480) 857–1991

You may also send a written complaint to the U.S. Department of Health and Human Services: DHHS (Office of Civil Rights), 200 Independence Ave S.W., Room 509 F HHH Building, Washington DC, 20201

Fees

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide minimum of one month's notice of any change to our fees.

Cancellation Policy

If you need to change or cancel your appointment, please do so with a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

Patient's Name **Patient's/Representative Signature** **Date**