Acupuncture Informed Consent to Treat

By signing below, I hereby voluntarily consent to be treated with East Asian Medicine including acupuncture and/or other Oriental Medicine modalities by a licensed acupuncturist at Natural Life Medicine. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is recommended by this clinic's practitioners.

I understand that treatment may include, but is not limited to, acupuncture, Chinese Herbal Medicine, cupping, Tui na, Gua sha, moxibustion, electrical stimulation and nutritional counseling.

Acupuncture: I have been informed that acupuncture is a generally safe method of treatment. I understand that acupuncture is performed by the insertion of sterile needles through the skin. I am aware it may have some side effects, including bruising, minor bleeding, minor pain or discomfort, dizziness or fainting, or numbness and tingling near the needling sites that may last a few days. Acupuncture is used to treat the underlying cause of the body's dysfunction or illness, to treat pain, and to treat the body's physiological functions. Acupuncture works with the nervous, musculoskeletal, cardiovascular, immune, and gastrointestinal systems to provide optimal function. I understand that no guarantees concerning its use and effects have been given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: the application of heat to the skin at certain points on the body.

- Indirect Moxibustion: The application of heat near the skin.
- Direct Moxibustion: The application of heat directly to the skin. I am aware this is not intended to be a painful experience. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Cupping: I understand that cupping is used to treat muscle pain. It is used to increase circulation and break up adhesion in muscle. I understand that cupping can cause bruising.

Chinese Herbs/Nutrition: I understand that herbs from the Oriental Materia Medica may be recommended to me to treat the underlying cause of the body's dysfunction or illness, to treat pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances, however, if I choose to take them I understand the herbs prescribed need to be prepared per instructions provided by the practitioner. Instructions may be provided orally and/or as part of a written treatment plan. I am aware that certain adverse side effects may result from taking these herbs and I will notify a member of the clinical staff of any unanticipated or

unpleasant effects. These side effects may include, but are not limited to: changes in bowel movement, nausea, gas, vomiting, abdominal pain or discomfort, headache, diarrhea, rashes, hives, tingling of the tongue, and the possible aggravation of symptoms existing prior to herbal treatment. I am aware that herbs and nutritional supplements are traditionally considered safe in the practice of Chinese Medicine, however some are toxic in large doses which is why I will follow the prescribed instructions. I understand that some herbs and supplements are inappropriate for pregnancy and I will promptly notify the practitioner if I am pregnant.

Tui-Na/Acupressure: I understand I may also be given tui-na which is a type of massage or acupressure as part of my treatment to modify or prevent pain and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse or stop the treatment at any time.

Electro-Acupuncture: I understand that I may be asked to be treated with electro-acupuncture using a TENs machine that would be attached to the needles. This method is generally painless. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment or stop at any time.

I understand there may be other treatment alternatives, including treatment offered by a licensed physician.

I understand that while this document describes major risk of treatment there may be other side effects and risks that can occur.

By voluntarily signing below, I show that I have carefully read, or have had read to me, the above consent to treatment. I have been told about the risks and benefits of East Asian Medicine and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____Date:_____
(In case of minor, parent or guardian must sign)

Printed Name:

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