

Acupuncture & Chinese Medical Center  
(Please Print)

Name \_\_\_\_\_ Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_ Home phone \_\_\_\_\_

E-mail \_\_\_\_\_

Today's date \_\_\_\_\_ Sex \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of birth \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ In case of emergency contact \_\_\_\_\_

Relationship \_\_\_\_\_ His/her phone \_\_\_\_\_

Recommended by \_\_\_\_\_

Main reason for treatment, list symptoms you currently have

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis and date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Significant accidents or operations \_\_\_\_\_

\_\_\_\_\_

**Please circle the condition**

**Habits:** Cigarettes Coffee Alcohol Recreational drugs Crave sugar Crave chocolate

Other \_\_\_\_\_

**Family history:** Arthritis Gout Asthma Cancer Diabetes

Heart Disease Strokes High Blood Pressure Kidney Disease Tuberculosis

Other \_\_\_\_\_

**CONDITIONS:** Please circle the condition (s) you currently have or have had in the past:

Anemia Anxiety Arthritis Asthma Bleeding Disorder Bronchitis Cancer Carpal Tunnel

Depression Diabetes Emphysema Goiter Gout Heart Disease Hepatitis Herpes

High Blood Pressure(Hypertension) High Blood Sugar High Cholesterol HIV Positive

Low Blood Pressure Low Blood Sugar Migraine Headaches Miscarriage Mononucleosis

Multiple Sclerosis On Blood Thinning Medication Prostate Problem Psychiatric Care

Seizures Stroke Thyroid Problem Other \_\_\_\_\_

## INFORMED CONSENT

I hereby request and consent to the performance of treatments within the scope of Traditional Chinese Medicine (TCM) on me (or on the patient named below for whom I am legal guardian) by Rou Wang (Doctorate in Oriental Medicine)/Acupuncture Chinese Medical Center. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, TDP lamp, cupping, electrical stimulation, and herbs; I also give Dr. Wang permission to use health information about my treatment for possible medical research or publication, without my name.

I understand that acupuncture is a generally safe method of treatment, but that may occasionally cause a drop of blood to appear after the needle is withdrawn (which is treated with direct pressure) or even create bruising at the needles site. Dizziness may occur as can nausea or lightheadedness and these reactions resolve with change of position or removal of the needles (I understand that it is best not to have an empty stomach before receiving an acupuncture treatment and to inform Dr. Wang if I suffer from “needle phobia”.) All of these reactions are very rare. Bruising is common with cupping, and TDP lamp or moxibustion can cause burns and/or scarring very rarely. Infection is always a risk with the use of needles, but this is minimized in acupuncture by using sterile, disposable needles; and it is almost never seen with acupuncture treatments. Sensations such as soreness, numbness, tingling, electrical sensations, or heaviness are a normal response to the needles and indicate that acupuncture is working. I agree to inform Dr. Wang immediately should any of these incidents occur.

Herbal remedies that are used in TCM are traditionally considered safe, particularly herbal combinations or “patent” formulas. It is important that these be taken in accordance with Dr. Wang’s instructions. Side effects are uncommon, but can include nausea, vomiting, or diarrhea. If any side effects should occur, I agree to contact Dr. Wang as to the appropriate course of action. I also understand that some herbs or acupuncture points may be inappropriate during pregnancy. I agree to notify Dr. Wang if I become pregnant during treatment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect Dr. Wang to be able to anticipate and explain all possible risks and side effects. I understand that results are not guaranteed. I understand that it is important for me to disclose my health history and present condition to Dr. Wang and this information will be kept confidential. In accordance with current privacy laws, I further understand that TCM is in no way the practice of medicine; and if I require medical treatment, I will seek out the appropriate professional. By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

PATIENT PRINT & SIGNATURE (or representative, indicate relationship if signing for patient)

Print: \_\_\_\_\_ Relationship \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

I consent to receive email and text (SMS) communications from this practice regarding my care, including appointment, billing, and clinical information that may contain protected health information (PHI). I understand that these communications are not secure, may be accessed by unauthorized parties or third-party service providers, and are not intended for urgent or emergency situations. By providing my contact information, I accept these risks, understand PHI risk acknowledgment and authorize this form of communication. I understand I may revoke this consent at any time.

Initials: \_\_\_\_\_