

Dr. Michelle D. Wu

Acupuncture & Herbal Medicine Clinic
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Phone: (425) 643-3758

Name:	Age:	Sex: M F
Phone (Home):	Phone (Work):	Ht. Wt.
Address:	City	Zip Code:
Date of Birth:	S.S. #:	Marital Status:
Employer:	Address:	Occupation:
Spouse's name:	Date of Birth:	Soc. Sec.#:
Spouse's Employer:	Work Phone:	Occupation:
In Emergency, notify:	Phone:	Relationship:
Family Physician:	Phone:	Referred by:

Patient informed consent is to advise the patient of the scope of practice of acupuncturists in the state of Washington. The "scope of practice" for an acupuncturist in the state of Washington includes, but not limited to, the following list of techniques:

1. Use of acupuncture needles to stimulate acupuncture points and meridians;
2. Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians;
3. Chinese herbal Medicine treatment;
4. Cupping;
5. Moxibustion;
6. Acupressure;
7. Point injection therapy;
8. Dietary advice based on Traditional Chinese medical theory;
9. Dermal friction technique (Gwa Sha).

Side effects of acupuncture may include, but not limited to, the following: some pain in the insertion area after treatment; minor bruising; infection; needle sickness and broken needle.

Side effects of Chinese herbal treatment may include, but not limited to, the following: gas; loss of appetite; loose stool and allergy to some herbals.

Patients, who have severe bleeding disorders, pace maker implants, electrical device implants, metal implants, or who are allergic to some food /medicine or pregnant, should inform the practitioner prior to any treatment.

I, the undersigned, Have read and understood the above information and voluntarily consent to the use of the above procedures for treatment. I understand that there is no guarantee regarding the success or effectiveness of a treatment or a series of treatments. I hereby release Dr. Michelle D. Wu from all liabilities in connection with these treatments. I understand that I am free to withdraw my consent and stop treatment at any time.

Patient's signature

Date

Patient' guardian' signature