North Shore Chinese Medicine Consent for Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese Medicine treatment techniques including but not limited to: electro-acupuncture, auricular acupuncture, moxibustion, acupressure, cupping, guasha, herbs or linaments by a licensed acupuncturist at North Shore Chinese Medicine, LLC. I understand that my acupuncturist will explain these modalities before use and that I may refuse treatment at any time. I understand that acupuncturists practicing in the state of Illinois are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort during or after treatment, and in very rare instances, pneumothorax.

Indirect Moxibustion: Moxibustion is the application of heat (using the herb Mugwort) near the skin at certain points, or near the surface of the body. I understand that if I receive moxibustion as part of therapy, there is a risk of slight redness or burning from its use.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat my health complaints. I understand that I must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, and abdominal pain or discomfort, or possible contraindications with my western-medicine prescribed medications. *If I experience any problems which I associate with these substances, I understand I should suspend taking them, seek medical advice id necessary, and call my acupuncturist as soon as possible.*

Acupressure: I understand that I may also be given acupressure as part of my treatment to modify or prevent pain perception 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.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to pain or discomfort during or after treatment.

Cupping: Cupping involves the use of small plastic cups placed over points on the body. Cupping creates a vacuum which stimulates the circulation within the superficial muscle layers. The suction effect usually leaves a red mark which fades over several days.

Guasha: Guasha is a healing technique that involves deeply stroking the skin using a round-edged instrument. The technique produces skin redness and sometime bruising, both of which dissipate in a few days.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I understand that results are not guaranteed. By voluntarily signing below I show that I have read, or have had read to me, this 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 name: _____ Date of birth: _____

Date:_____ Signature (parent/guardian if patient is minor):_____