



# East Acupuncture Wellness Boutique

2296 US-70, Swannanoa NC 28778

828.458.4139

info@eastacupuncturewb.com

www.eastacupuncturewb.com

## INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists of Ashley Kuper, L.Ac.. I understand that acupuncturists practicing in the state of North

Carolina 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 practitioner. I understand that I may refuse any of the following treatments at any time:

**Acupuncture:** I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or disease, 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 may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection.

**Moxibustion:** Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin, intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa.

**Electro-Acupuncture:** I understand that I may receive electro-acupuncture, which involves the stimulation of acupuncture points with a mild electric current. This treatment is stimulating but not typically painful or shocking. I am aware that certain adverse side effects may result from this treatment., including, but not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

**Gua Sha/Cupping:** I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soup spoon. Cupping applies localized suction to the skin with glass cups, drawing the superficial muscle layer into the cup. Both are used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, soreness, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

**Acupressure/Massage:** I understand that I may receive acupressure or massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

**Chinese Herbs:** I understand that Chinese herbs may be recommended as part of my treatment. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These may include, but are not limited to: changes in bowel movement, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. If I associate any concerns with the use of the herbal substances, I should stop use immediately and call my acupuncturist.

**Dietary & Exercise Advice:** In conjunction with my treatment, I may be given advice and suggestions concerning changes in diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Suggestions concerning physical activity and exercises may also be included in my treatment. I will communicate with my practitioner about any difficulties I may have with specific dietary or exercise recommendations.

***Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with acupuncture or herbal medicine.***

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature of Patient/Guardian/Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient/Guardian/Personal Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Printed Name of Patient, if different from signer above: \_\_\_\_\_ Date: \_\_\_\_\_



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Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: \_\_\_\_\_ Email address: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Contact # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Have you ever used Chinese medicine for your health care? \_\_\_\_\_  
For what reason? \_\_\_\_\_

## Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Western Medical Diagnosis (if you have one) \_\_\_\_\_

Please list three things you would like to change about your health and well-being.

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

Is there anything else you would like me to know?

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

Thank you for taking the time to complete this form. I look forward to working with you!