[A l c h ė m y̆]

62 Clayton Street, Asheville, NC 28801

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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 Alchemy, LLC. 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.

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 soupspoon. 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/Tui Na Massage: I understand that I may receive acupressure or tui na 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:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Policies for healthcare services at the Clinic.

Patient's Signature: Date:

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Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. We will also discuss these questions on the first visit. Thank you for being here!

Name: _____ Date: ____/____/_____
Last, First

Telephone: Home: _____Work: _____ Cell: _____

Mailing Address: _____

Email address: _____

Height_____ Weight_____ Age_____ Date of Birth: _____ Occupation _____

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.			

Please list all medications (prescription and over-the-counter) and supplements that you are taking or have taken in the past for longer than 3 months. Please also note the reason for which each is taken.

Dosage Reason How long

_____
_____

For Practitioner Use

Chief Complaint/Intake:

Pulse/Tongue/Observation:

Points:

Recommendations: