

**WASHINGTON STATE ACUPUNCTURE & CHINESE MEDICINE CENTER**

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***PATIENT QUESTIONNAIRE & CONSENT***

The law requires patients receiving acupuncture to give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the credentials of the practitioner and the scope of the practice of acupuncture in the State of Washington.

The practitioner, Dr. Salina Chan, is licensed in the State of Washington. She graduated from Bastyr University with a Doctorate degree in Naturopathic Medicine, and a Master degree in Acupuncture and Oriental Medicine. She has received additional Chinese herbal medicine training in gynecology from Beijing University of Chinese Medicine in Beijing, China.

As stated by law, therapy acupuncturists in the State of Washington are allowed to use the methods listed below. This in no way means that all these methods will actually be used for your treatment. You will be advised before any one of these methods is to be applied, and you always have the right to decline.

1. Use of acupuncture needles to stimulate acupuncture points
2. Use of electrical, magnetic, or mechanical devices to stimulate acupuncture points
3. Moxibustion (direct or indirect application of heat on acupuncture points using herbal materials)
4. Acupressure
5. Cupping
6. Dermal friction
7. Infra-red light
8. Sono-puncture (ultrasound)
9. Laser puncture
10. Dietary advice based on traditional Chinese medical theory

Patients with the following conditions must inform the practitioner prior to receiving acupuncture treatments. Please check the following that applies.

- \_\_\_\_\_ pregnancy
- \_\_\_\_\_ pacemaker
- \_\_\_\_\_ severe bleeding disorders
- \_\_\_\_\_ hepatitis
- \_\_\_\_\_ AIDS or HIV positive

I, the undersigned, have read and understood the foregoing information and voluntarily consent to the use of the above procedures for treatments. I understand that there is no guarantee implied or expressed regarding the success or effectiveness of a treatment or a series of treatments. I hereby release **Salina Chan, ND LAc**, and the assistant under the supervision of her, from all liability in connection with these treatments. I understand that I am free to withdraw my consent and stop treatment at any time.

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

Patient Name (please print): \_\_\_\_\_