



Consent to Treatment Form

I understand that I will be given acupuncture / acupressure / tui na / shiatsu massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological function. 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, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____