ACUPUNCTURE/MASSAGE CONSENT TO CARE

I AM VOLUNTARILY WISHING TO EXPERIENCE A SESSION(S) OF ACUPUNCTURE/MASSAGE CONDUCTED BY OUR PROFESSIONALLY TRAINED TRADITIONAL CHINESE MEDICINE SPECIALIST.	YES/NO
I UNDERSTAND THAT AN ACUPUNCTURIST/MASSAGE THERAPIST DOES NOT DIAGNOSE ILLNESS, PRESCRIBE MEDICATIONS, OR MAKE SPINAL ADJUSTMENTS.	YES/NO
I UNDERSTAND ACUPUNCTURE/MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL CARE OR TREATMENT.	YES/NO
I HAVE ALERTED MY THERAPIST TO ANY CONDITIONS I HAVE WHICH MAY AFFECT THEIR WORK AND I HAVE DISCLOSED ALL MEDICATIONS (BOTH HERBAL AND PHARMACEUTICAL) THAT I AM CURRENTLY TAKING.	YES/NO
I AGREE TO UPDATE MY PRACTITIONER TO ANY CHANGES IN MY MENTAL, EMOTIONAL OR PHYSICAL HEALTH.	YES/NO
I AM SEEKING ACUPUNCTURE/MASSAGE OF MY OWN ACCORD FOR THE PURPOSES THAT ACUPUNCTURE/MASSAGE IS INTENDED. THESE INCLUDE, BUT ARE NOT LIMITED TO IMPROVED CIRCULATION, MUSCLE AND JOINT SORENESS, RANGE OF MOTION AND MENTAL WELLNESS.	YES/NO
I UNDERSTAND AND HAVE BEEN EXPLAINED TO ME THE PROCEDURE, BENEFITS AND CONTRAINDICATIONS FOR ACUPUNCTURE/MASSAGE AND THE SIDE EFFECTS WHICH MAY OCCUR AS A RESULT OF ACUPUNCTURE/MASSAGE.	YES/NO

Print Name ____

FIRST MIDDLE LAST

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SIGNATURE DATE

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