Dr. Linda Z. Wu
Registered Acupuncturist

Informed Consent
For Acupuncture Care

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxabustion., cupping, acupressure, laser, electro acupuncture, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the registered acupuncturists named above and / or anyone working in this clinic authorized by the registered acupuncturists listed above.

I have had the opportunity to discuss with the registered acupuncturists and / or anyone with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of acupuncture even though all needles are pre-sterilized and disposable there are some slight risks to treatment including but not limited to temporary soreness, bruising, nausea, fainting, bleeding, infection, and shock. I do not expect the acupuncturists to be able to anticipate and explain all the risks and complications and wish to rely on the acupuncturists to exercise judgment during the course of the procedures which the acupuncturists feels at the time, based upon facts then known, are in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: ______________________________ Printed Name: ______________________________

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Date

The following information will be helpful to Dr. Linda Z. Wu in her treatment and recommendations.

Date ____________________ Referred by ____________________

Name ____________________ Birthday ____________________

Res. Address ____________________ Postal Code ____________________

Bus. Address ____________________ Occupation ____________________

Tel. Residence ____________________ Tel. Business ____________________

Cell Phone: ____________________

1. Reason for your visit to the clinic with respect to the complaint: ____________________

   Your major illness in the past: ____________________

   Previous Diagnosis: ____________________ By Whom ____________________

2. Are you presently under the care of a medical doctor, a hospital.,or any other kind of health care professions?

   Yes ___ No ___ if yes, please specify ____________________

3. Have you ever sustained any physical injuries as a result of an accident? If yes, please specify below:

   When and where did it happen ____________________

   What injuries did you sustain ____________________

   What treatment did you receive ____________________

   What residual defects or limitations do you have now ____________________

4. Are you presently taking any kind of medication or nutritional supplement? If yes, please specify:

Name	Dosage	Prescribed by whom

5. Have you had any surgery? If yes, please specify:

When	For What Purpose	What Type of Surgery
______________	______________	______________
______________	______________	______________
______________	______________	______________

6. Have you had asthma,eczema, or allergies to any drug, chemicals, herbs, food, or animal hair? If yes, please specify: ______________________________________

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CANCELLATION POLICIES

A specific time of appointment is reserved just for you. If you are unable to keep the appointment, please give us at least 24 hours notice so we may reschedule another time for you.

If you miss/cancel an appointment without a minimum of 24 hours notice, there will be a $20 charge. The money will be donated to one of the following non-profit organizations of your choice:

( ) World Vision Canada
( ) Foster Parents Plan
( ) Alberta Children's Hospital Foundation
( ) Other (please specify)

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In the case the money cannot be delivered to the organization you choose, we will redirect the money to the other non-profit organization(s).

I hereby **declare** that the above information is correct and that I have not withheld any medical information specifically requested.
I hereby consult Dr. Linda Z. Wu on alternate therapies other than the orthodox medical therapies such as drugs, surgery, chemotherapy, radiation, etc. These alternate therapies may include acupuncture treatment , acupressure, Chinese herbs, vitamins, enzymes, nutritional programs, diet balancing, etc. It is my desire to choose these therapies and to take full responsibility for choosing and administering these therapies to myself. I realize these therapies are not approved by the majority of the medical profession and that there is at present no orthodox medical acceptance of their value.

______________________ ______________________

Patient's Signature Date