

Informed Consent For Acupuncture



Please read carefully

I, the undersigned, do hereby give my voluntary consent for the administration of medical acupuncture and the ancillary techniques as deemed appropriate by my therapist.

Acupuncture has been explained to me as a therapeutic treatment performed by the insertion of single use, sterile, disposable needles. The needles are inserted through the skin, into the underlying muscles and tissues at specific points on the body for the purpose of alleviating pain, relieving pressure on nerves, improving mobility and re-establishing normal function.

Ancillary techniques of acupuncture may include one or more of the following:

- Electro-acupuncture – where the needles are electrically stimulated at various frequencies to increase the therapeutic benefit.
- Dry needling – where muscles are briefly needled by an acupuncture needle, held in a needle holder, to release trigger points and spasms.
- Cupping – where suction cups are applied to specific points or regions of the body.

I understand that there is the possibility of temporary complications which may result from the above procedures, which include, but not limited to minor bleeding, bruising, soreness, nausea, weakness, fatigue, fainting or aggravation of existing symptoms for a short time. On the rare occasion, an individual may experience an infection, convulsion or stuck needles.

I further state that the following do not exist in my current state of health and I will immediately notify of any changes:

*Pregnancy

*Local Infections

*Pacemaker

*Anticoagulants

*Bleeding Disorders

*Elevated Risk of Infections

I do not expect the acupuncture practitioner to be able to anticipate and explain all the risks and complications. I wish to rely on the therapist, to exercise proper judgement during the course of the treatment to make decisions based upon my best interests.

I accept the fact that there is no guarantee of the effectiveness of the treatment.

I am aware that I may withdraw the consent and discontinue treatment at any time.

I hereby certify that I have read the above information and have had my questions answered to my satisfaction. By signing below, I agree to the above-mentioned acupuncture procedures.

Date

Patient Name (Print)

Patient Signature

Therapist