**Template for Medical Acupuncture Consent**

Please ensure you complete all the fields. You may choose to skip answering any question you feel impinges on personal information you do not wish to disclose.

**Personal Information**

|  |  |
| --- | --- |
| 1. Full Name:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Resident of:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Birth Date:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. E-mail:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Contact:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Occupation
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 1. Emergency Contact
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Allergies, if any:
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Medications, if any taken or taking
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you ever had Acupuncture before?
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. If yes, was the treatment effective?
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

The following questions relate to your current and previous health condition. All information will be kept hidden and maintained confidentially. No information will be disclosed or shared without your written consent.

Have you ever been diagnosed with any of the following?

|  |  |
| --- | --- |
| * Asthma
* Diabetes
* Cancer
* Hepatitis
* Epilepsy
* HIV/AIDs
* Tuberculosis
* Multiple Sclerosis
* Polio
* Leukemia
 | * SARS/Birds
* FLU
* Heart Disease
* High Blood Pressure
* High Cholesterol
* Depression
* Anxiety
* PTSD
* IBS
* Autoimmune Disease
 |

Please complete the following questionnaire to the best of your knowledge.

**Past operations, injuries & health history, if any.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Major Ailment

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Describe the beginning of the Major Ailment.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Describe the medical tests you had for its treatment and its result?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Frequency of pain or discomfort. Please select the most accurate
* Constant
* Off/On
* At rest
* With activity
1. At what time of day is the pain or discomfort at its worse?
* Morning
* Afternoon
* Evening
* Sleep
1. Have you ever injured with this area before?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been in any accident (automobile, work, falls, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List all related treatments received for this condition.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever received acupuncture for a specific problem or injury?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there anything that you do that increases or decreases discomfort or pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are the physical duties required of your occupation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What activities/hobbies do you enjoy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many children do you have?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any exercise or relaxation/stress reduction activities you do (including frequency).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate if you see any other healthcare practitioners from the list below?

|  |  |
| --- | --- |
| * Chiropractor
* Naturopath
* Osteopath
* Kinesiologist
* Physiotherapists
* Exercise Physiologist
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Reiki
* Nutritionist
* Feldenkrais
* Massage Therapist
* GP
* Energy Balancing Therapist
* Pilates
 |

1. Who is your General Doctor?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any symptoms that apply to you or mention if there’s any other.

**Digestion & Bowels**

|  |  |
| --- | --- |
| * Bloating
* Pain or discomfort
* Pain above navel
* Pain below navel
* Lower abdomen
* Right side abdomen
* Left side abdomen
* Cramping pain
 | * Constipation
* Acid taste
* Sour taste
* Bitter taste
* Sugar cravings
* Pain relieved with passing wind
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Breathing & Sinus**

|  |  |
| --- | --- |
| * Difficulty in breathing
* Short of breath
* Asthma
* Cough
* Throat irritation
* Ringing in ears
* Difficulty in swallowing
* Phlegm
 | * Blocked feeling in throat
* Allergies
* Nasal discharge
* Post nasal drip
* Blocked nose
* Nose surgery
* Nose injury
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Heart and Blood vessel Circulation**

|  |  |
| --- | --- |
| * High blood pressure
* Low blood pressure
* Pain in chest
* Dizziness
* Stroke
* DVT
* Surgery
 | * Diagnosed heart disease
* Blocked arteries
* Varicose veins
* Numbness
* Pins and needles
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Urination**

|  |  |
| --- | --- |
| * Incontinence
* Pain while passing urine
* Urgency with pain
* Urgency without pain
* Long stream
* Short stream
* Prostrate condition
* Kidney disease
* Cystitis
 | * Burning sensation
* Dark yellow color
* Orange color
* Pale straw color
* More than 5 times during day
* More than once during night
* Diagnosed UTI
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Skin, Hair, Nails & Dental**

|  |  |
| --- | --- |
| * Dry skin
* Rashes
* Cracked skin on fingers
* Acne
* Cracked nails
* Ridges on nails
* Toothache
* Tooth nerve pain
* Dandruff
 | * Dermatitis
* Alopecia
* Psoriasis
* Eczema
* Fungal infection
* Gingivitis
* Gum infection
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Menstruation**

|  |  |
| --- | --- |
| * Irregular periods
* Heavy periods
* Pain or cramping
* Amenorrhea
* Dysmenorrheal
* Congealed blood
* Hormone tests
* Pain medication
* Headache
* Back pain
* Laparoscopy
 | * Anxiety
* Depression
* Spotting
* Change bowels
* Nausea
* Endometriosis
* D&C
* PCOS
* Using IUD or contraceptive pills
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

At what age did you have your first period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how many days is your period cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the color of discharge at the start of your period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head**

|  |  |
| --- | --- |
| * Headaches
* Tension in templates
* Dizziness
* Ringing in ears
* Fainting
* Sinus congestion/Nasal discharge
 | * Light headedness
* Around eyes
* Red eyes
* Irritated eyes
* Weepy eyes
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Neck**

|  |  |
| --- | --- |
| * Disc herniation
* Pain at the base of the neck
* Pain when moving side to side
* Pain when turning
* Neck feels out of place
* Bone spurs
 | * Muscle spasm in neck
* Stiffness
* TMJ disorder
* Arthritis
* Whiplash
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Shoulders**

|  |  |
| --- | --- |
| * Pain in shoulder – front/back/top
* Pain with activity
* Pain at rests
* Pain wakes from sleeps
* Pain in morning while walking
 | * Bursitis
* Arthritis
* Shoulder surgery
* Can’t raise arm above shoulder
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Arms and Hands**

|  |  |
| --- | --- |
| * Pain in upper arm
* Pain in forearm
* Pain in wrist
* Pain in fingers
* Fingers go to sleep
* Sore joints in fingers
* Swollen joints
 | * Sensation of pins and needles
* Diagnosed arthritis
* Loss of grip strength
* Hands cold
* Sensation referred down arm to hand
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Mid-Back**

|  |  |
| --- | --- |
| * Mid-back pain
* Pain with breathing
* Pain between shoulder blades
* Pain up/down back
* Restricted movement
 | * Pain along spine
* Pain around entire torso
* Tight along sides of torso
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Low Back**

|  |  |
| --- | --- |
| * Low back pain
* Pain in worse working
* Pain in worse lifting
* Pain in worse standing
* Pain in worse sitting
* Pain in worse bending
* Pain in worse coughing
 | * Pinched nerve
* Disc herniation
* Low back feels out of place
* Arthritis
* Surgery
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Legs and Feet**

|  |  |
| --- | --- |
| * Pain down in right leg
* Pain down in left leg
* Leg cramps
* Sweaty feet
* Swollen foot
* Cramps in foot
* Cold feeling
* Diagnosed arthritis
 | * Pain in right knee
* Pain in left knee
* Knee surgery
* Numbness in loss
* Pin & needles
* Injury
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Hip**

|  |  |
| --- | --- |
| * Pain in buttocks
* Pain in side of hip
* Pain in hip joint
* Pain in side of a leg
* Pain in back of a leg
* Pain in sir bone
 | * Diagnosed bursitis
* Diagnosed arthritis
* Surgery
* Injury
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, solemnly declare that particulars given above are true correct to my best knowledge and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s name and signature)

**Please sign your initials after reading the T&C on the very next page, that you have received and understand our policy.**

**Medical Acupuncture Consent Form**

(Clinic’s name)

**“ACUPUNCTURE”** means the stimulation of a certain point or points near the surface of the body by installation of thin needles. Medical acupuncture involves insertion of fine, solid stainless steel needles into the skin at specific points on the body to achieve a therapeutic effect. It also often serves in the treatment of certain diseases or dysfunctions of the body.

* Acupuncture may allow the painless relief of one’s symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problems.
* You should also know about the risks involved: Although acupuncture is generally safe and serious problems are rare. But there may be some risks. Needles which are not sterile can cause infection. Make sure that your practitioner uses sterile needles which are thrown away after one use. Here, it should bring to your knowledge that **we only use new, disposable sterile needles, so infection is rare**.

In some acupuncture points, needles inserted too deeply which can puncture the lungs or gallbladder or cause problems with your blood vessels. That is why it is important to use a practitioner who is well-trained in acupuncture.

* Herbal Remedies: The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify my practitioner if I experience any of the above-mentioned side effects or if I become pregnant.

I have read the above, understand the risks involved, and consent to medical acupuncture treatment. By voluntarily signing below, I show that I have read the above and give my consent for the treatment.

I accept full responsibility for payment of all treatment fees.

Patient’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_