**ACUPUNCTURE CONSENT FORM**

**Patient Information and Consent Form**

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

**What is acupuncture?**

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

**Is acupuncture safe?**

Acupuncture is generally very safe. Serious side effects are very rare-less than one per 10,000 treatments.

**Does acupuncture have side effects?**

You need to be aware that:

* *Drowsiness occurs after treatment in a small amount of patients, and, if affected, you are advised not to drive;*
* *Minor bleeding or bruising occurs after acupuncture is about 3% of treatments;*
* *Pain during treatment occurs in about 1% of treatments;*
* *Existing symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign;*
* *Fainting can occur in certain patients, particularly at the first treatment.*

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

**Is there anything your practitioner needs to know?**

Apart from the usual medical details, it is important that you let your practitioner know:

* *If you have ever experienced a fit, faint or funny turn;*
* *If you have a pacemaker or any other electrical implants;*
* *If you have a bleeding disorder;*
* *If you are taking anti-coagulants or any other medication;*
* *If you have damaged heart valves or have any other particular risk of infection.*

Single-use, sterile, disposable needles are used in this clinic.

**Statement of Consent**

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Print name in full: \_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print name in full: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_