Acupuncture Consent Form

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Address: _____ Phone Number: _____

Emergency Contact Name & Number

PURPOSE OF ACUPUNCTURE TREATMENT

Describe the condition or purpose of treatment

Proposed treatment plan (frequency and duration)

Potential risks and side effects

Expected benefits

PATIENT MEDICAL HISTORY

Current medications

Known allergies

Previous acupuncture treatments

Other relevant medical history

CONSENT TO TREATMENT

I, the undersigned, hereby voluntarily consent to the administration of acupuncture treatments and other procedures within the scope of the practice of Oriental Medicine as deemed necessary by my naturopathic physician and Oriental Medical Doctor. I understand that I may ask questions about my treatment before signing this form and that I may withdraw my consent at any time. I have been informed of the potential risks, side effects, and benefits of acupuncture, including but not limited to minor bruising, fainting, and temporary discomfort.

Signature of Patient

Signature of Physician