**ACUPUNCTURE INFORMED CONSENT FORM**

|  |  |
| --- | --- |
| PATIENTS NAME: |  |
| DOB: |  |

**EXPLANATION** – *This will be given by the therapist prior to treatment*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Treatment procedure/ Intended benefits |  |  |
| Stimulation of needles |  |  |
| Advice leaflet provided |  |  |

**CONTRAINDICATIONS** – *Please tick below if you suffer any of the following conditions*

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Phobia of needles |  |  |
| Acute Cardiac Arrhythmia/ Pacemaker |  |  |
| History of recent stroke or undiagnosed seizures |  |  |
| Confused/ Unsuitable patient |  |  |
| Allergy to metal |  |  |
| Anticoagulation/ haemophilia (contraindicated unless INR checked and stable) |  |  |
| Unstable Diabetes |  |  |
| Unstable Epilepsy |  |  |

**PRECAUTIONS**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Pregnancy (contraindicated in 1st trimester) or might be pregnant |  |  |
| Angina |  |  |
| Poor Skin condition/ Infection / areas of poor circulation |  |  |
| History of lymphodema/ Lymph node clearance |  |  |
| History of strokes/ undiagnosed seizure |  |  |
| Unstable hypertension/ hypotension |  |  |
| Immunosuppressive disorders |  |  |
| Hungry Patient (ensure you have eaten prior to treatment) |  |  |
| Cancer History |  |  |
| History of Long term steroids |  |  |
| History of fits/faints “funny turns” |  |  |
| Frail patients/ weak constitution |  |  |
| Lumps/ Moles / Cancerous growths |  |  |
| Hypertension/Hypotension |  |  |
| Areas of reduced sensation |  |  |
| Swelling/DVT/CRPS |  |  |
| Any other medication |  |  |

**RISKS/ SIDE EFFECTS** - *Your therapist and the information leaflet will explain these prior to treatment so that you understand that these are possible side effects. If preferred these can be ticked at time of treatment with your therapist.*

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Possible Drowsiness – warned not to drive/operate machinery until rested |  |  |
| Possible Fainting |  |  |
| Possible Bruising/ Haematoma/Bleeding |  |  |
| Possible Nausea |  |  |
| Possible Injury to internal organs – (Very rare/certain points only) |  |  |
| Possible Broken needle/Stuck needle (Very rare) |  |  |
| Possible Post treatment soreness |  |  |

The purpose, benefits and potential risks of acupuncture treatment have been explained to me.

I confirm that I have understood the information given and I consent to having acupuncture treatment. I understand that I can withdraw from treatment at any time.

Signature:…………………………………….. Date:…………………