

Acupuncture Consent Form

Patient Information:

Full Name:

Date of Birth:

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 (or Parent/Guardian):

Date:

Signature of Physician:

Date: