

Patient Informed-Acupuncture Consent to Treatment

Body Flex Physio & Rehab Clinic

Patient Name:	
DOB:	

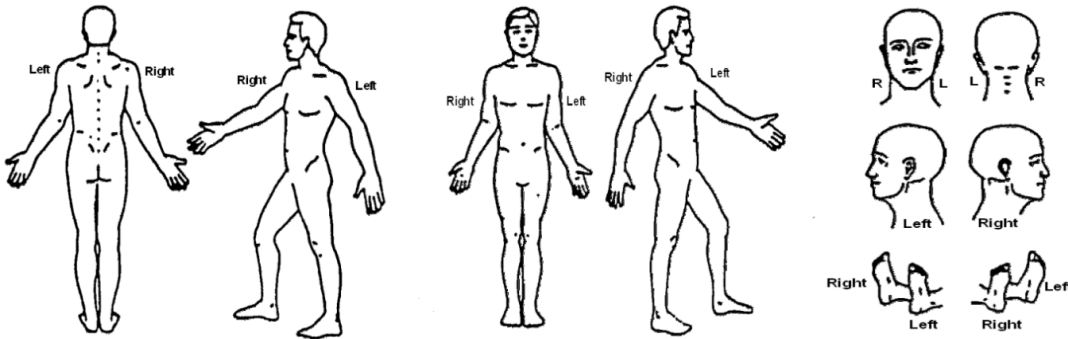
consent to have Acupuncturist perform the following treatment* on me: Describe specific treatment or specific plan of treatment. For example, acupuncture and herbal prescription for 8 weeks, with at-home exercises. [Note that the practitioner should not obtain a "blanket consent" to cover every procedure when the patient first comes in.]

*If treatment includes sensitive areas, I, consent to have Acupuncturist provide assessment and/or treatment of the areas indicated below: [please check the appropriate box(es)]

- | | |
|--|---|
| ☐ Upper and inner thigh | ☐ Vagina |
| ☐ Buttocks | ☐ Breasts |
| ☐ Penis | ☐ Chest wall muscles |

1. Where is your primary pain problem? _____

Using the figures below, shade the areas where your pain usually occurs:



2. What type of pain do you have?							
Sharp Pain	Dull Pain	Ache	Burning Sensation	Stabbing Pain	Numbness	Tingling	Stiffness
3. Using the following Pain Scale, rate your pain:							
0 = No Pain	1-3 = Mild	4-6 = Moderate	7-9 = Severe	10 = Hospitalized			
4. How is your sleep?							
Very good		Good	Fair	Poor	Very poor		
5. Do you smoke or consume alcohol?							
Yes	Please specify:					No	
6. How are stress levels?							
None	Mild	Moderate	High	Severe			
7. Do you take caffeine?							
Yes	If yes, how many cups a day?					No	
8. How much water do you drink per day? Glasses:							
9. How is your appetite?							
Normal	Mildly reduced	Significantly reduced	Increased appetite	Fluctuating			
10. How are the bowel movements?							
Regular	Constipation	Diarrhea	Alternating constipation and diarrhea				
11. Any changes in urination?							
Yes	If yes, please specify:					No	

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I acknowledge that Acupuncturist has explained the following to me:

- the nature of the treatment, as set out above
- if applicable, the clinical reason(s) for the assessment of the above sensitive area(s) and the draping methods to be used the expected benefits of the treatment
- the material risks of the treatment
- the material side effects of the treatment
- the alternatives to having the treatment
- the likely consequences of not having the treatment

I acknowledge that my practitioner cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my practitioner about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that my consent is voluntary, and I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my practitioner has explained the applicable fees to me.

I acknowledge that I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand.

By signing this form, I give my informed consent for the treatment set out above.

Signature of Patient/SDM: _____ **Date**_____