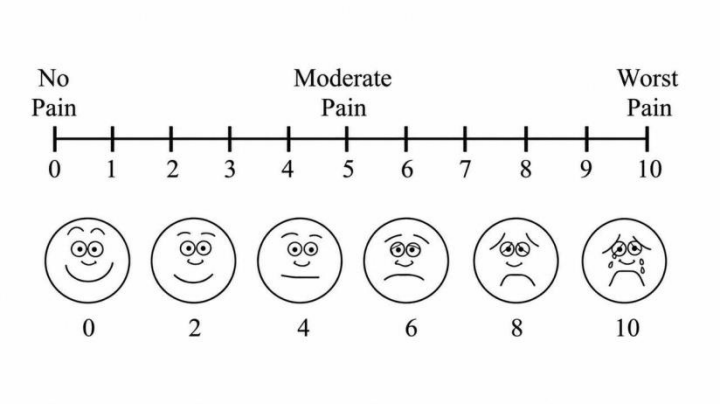
Acupuncture Consent Form

First Name:	
Last Name:	
DOB:	

1. **Where is your primary pain problem? _____**

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:



4. How is your sleep?					
	Verygood	Good	Fair	Poor	Verypoor

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

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 Acupunctur ist provide assessment and/or treatment of the areas indicated below: [please check the appropriate box(es)]

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

I acknowledge that Acupuncturist has explained the following to me

If applicable,the clinic alreason(s)for the assessment of the above sensitive area(s)and the draping methods to be used the expected benefits of the treatment

- 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 (please use your First name and Last name): _____ **Date**_____