Family Acupuncture Clinic

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Consent Form

Name _____ D.O.B. ____/____/_____ Age _____

Address _____

Preferred Phone _____ Email _____

Occupation: _____ Blood Type: A/B/AB/O

GP: _____/Ph._____ Last visit: ___/____/_____

Referred by _____

Emergency Contact: Name _____ Phone _____

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures on me (or on the patient named above, for whom I am legally responsible) by Helena Fitzgerald. I understand that methods or treatment may include, but are not limited to: acupuncture, Shonishin, Moxibustion, cupping, moving cupping, electrical stimulation, supplement recommendations, and nutritional counselling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There may be some bruising after cupping.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgement during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand that the clinic would expect me as the patient to bring to their attention any issues which might prejudice treatment, such as the presence of pacemakers, infectious disease, any serious illness, or any impending operations.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: _____/_____/_____
Patient's/Patient Representative's