Acupuncture Medical Consent

Personal Information

Full Name

Birth Date

Occupation

Address

E-mail

Phone Number

Emergency Contact

Allergies and Medication

Have you ever had Acupuncture before?

Yes No

If yes, was the treatment effective?

Client's Medical History

Please complete the following questionnaire to the best of your knowledge. Further questions may be asked by your practitioner regarding the information provided here.

Past operations, injuries & health history

1. Main complaint - Please specify

2. Describe the onset of the main complaint

3. What medical testing have you had for this condition? What were the results?

4. Frequency of pain or discomfort - please select the most accurate

Rarely ◯ Sometimes ◯ Always ◯

5. At what time of day is the pain or discomfort at its worse?

6. Have you ever injured this area before? If yes, please describe.

7. Have you ever been in an accident (automobile, work, falls, etc.)?

8. List all related treatments received for this condition.

9. Have you ever received acupuncture for a specific problem or injury? If yes, when?

10. Is there anything that you do that increases or decreases discomfort or pain?

11. What are the physical duties required of your occupation?

12. What activities/hobbies do you enjoy?

13. Please list any exercise or relaxation/stress reduction activities you do (including frequency)?

Acupuncture Medical Consent Template

I, _____ _____, have been informed about the nature of the acupuncture treatment, that involves insertation of thin, sterile needles into specific points of the body and hereby consent to receive this treatment.

I know and understand that accupuncture may provide various benefits, including pain relief, stress reduction, balance and body function etc. and considered safe. But the treatment also may risks and side effects. I have been informed about the risks and side effects including soreness, minor bleeding, bruising.

I have been informed about how my all medical information is used, stored and I know and aware of my rights regarding my medical data.

By signing below, I acknowledge that I have been informed and understood the information provided. I have had the opportunity to ask questions and received satisfactory answers to my inquiries.

Patient's Name

_____ _____

Date _____

Signature

_____

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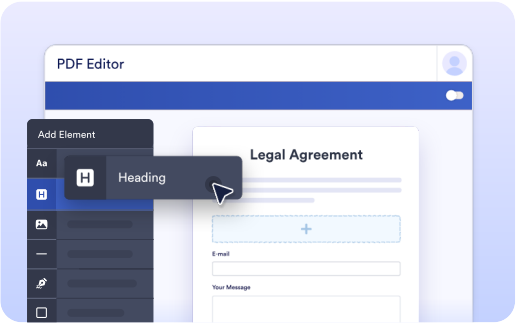

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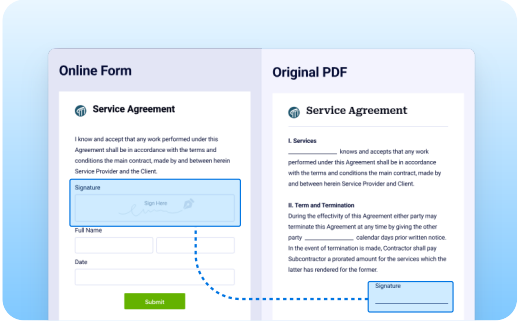

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