physiomobility HEALTH GROUP

Patient ID: _____

Consent for Acupuncture Assessment &Treatment

By Signing below, I hereby agree and consent to the performance of acupuncture. I understand that such procedures may include, but are not limited to acupuncture, Electric or laser acupuncture, acupressure, Cupping, Moxabustion and nutritional counseling based on traditional Chinese medical theory. I understand that the treatment will be administered by a registered acupuncturist.

Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. Electrical acupuncture is application of Electrical current to stimulate acupuncture points and needles. Acupressure is a form of treatment applying pressure on acupuncture points used in facilitating healing and pain management. Manipulating the body with this type of massage promotes blood accumulation and removes blood stasis. Bruising may be a potential risk. Cupping involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Burns or blisters although rare are also potential risks.

I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: bleeding disorders, pacemaker, local infections, and am not currently taking anticoagulants. If I have any of the above conditions, I have listed them here:

_____

By voluntarily signing below I, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____ Signature: _____

Date: _____

Practitioner Name: _____

☐ ***Physiomobility*** DON MILLS
6 Maginn Mews, Suite 211
Shops at Don Mills
Tel: 416-444-4800
Fax: 416-444-4811

☐ ***Physiomobility*** THORNHILL
8150 Yonge St. Suite 1
Yonge & Uplands
Tel: 905-731-6777
Fax: 905-731-3336

☐ ***Physiomobility***
HOME HEALTHCARE
Central & North GTA
Tel: 416-444-9547
Fax: 416-444-4811

☐ ***Pain Management & Fibromyalgia Centre***
211-A- 6 Maginn Mews
Tel: 416-444-0699
Fax: 416-444-4811