

Patient Name:

Patient DOB:

Acupuncture in Physiotherapy Consent Form



Intended benefits of treatment

- Reduction of pain
- Alleviation of muscle spasm and tension
- Facilitation of the healing process
- Induction of local and general relaxation
- Promotion of general well-being
- Improvement of sleep pattern

Possible adverse effects

The following are the known (based on research evidence) possible adverse effects associated with acupuncture, your physiotherapist will discuss these with you and explain if you are at any enhanced risk.

- Bleeding and Bruising (3%)
- Mild aggravation of symptoms (3%, of which 70-85% show subsequent improvement)
- Mild Pain at the needle site (1%)
- Drowsiness (1%)
- Dizziness (0.6%)
- Pain not at needle site (0.5%)
- Nausea (0.3%)
- Feeling faint (0.3%)
- Stuck or bent needle (0.1%)
- Headache (0.1%)
- Allergy or infection (up to 0.2%)
- Pneumothorax (0.0002%/ less than 2 per 1 million)

Although acupuncture in an established procedure, there may be other adverse effects that have not been recorded. If you experience any of the above or notice anything unusual about your health following your treatment then you should contact your physiotherapist or GP straight away.

Statement of consent

I confirm I have read, understood and have had the opportunity to ask questions related to the information on this form and the leaflet titled '**Ask your Physiotherapist about Acupuncture**' produced by the Acupuncture Association of Chartered Physiotherapists. Specifically I understand what the treatment is likely to involve, the intended benefits and possible adverse effects, therefore I give consent to having acupuncture treatment. I understand I can withdraw from the treatment at any time. I agree not to disturb the needles during the treatment period and will ask for assistance if I have any concern.

Patient signature Date

Patient name (print in full)

I confirm that I have explained to the patient the above information and have witnessed them sign this consent form.

Physiotherapist signature Date

Physiotherapist name (print in full)

References on file.

Patient Name:

Patient DOB:

Acupuncture in Physiotherapy Health Screening Form



You will need to answer the following questions honestly and to the best of your ability. This is to ensure that you will not be subjected to any enhanced risk of adverse effects prior to acupuncture treatment.

Health questions	Yes	No
Do you suffer from diabetes?		
Have you ever experienced an epileptic seizure?		
Have you ever fainted?		
Do you have any heart problems?		
Do you have a pacemaker or any other electrical implant?		
Do you have any problems with your circulation such as Deep Vein Thrombosis, Pulmonary Embolism or a bleeding or clotting disorder?		
Are you receiving anticoagulation therapy?		
Do you have, or have you ever suffered from any form of cancer?		
Are you aware of any blood borne viruses such as HIV, AIDS, or Hepatitis?		
Do you have any allergies? (specifically to metal or alcohol wipes)		
Are you pregnant or trying to conceive?		
Do you have a phobia to needles?		
Have you ever experienced any adverse effect to previous needling procedures such as acupuncture or injections?		
Have you eaten/ will you eat within 2 hours prior to your acupuncture treatment?		
Further information:		

Declaration

I confirm I have answered the questions honestly and to the best of my knowledge. I know of no reason that I should not have acupuncture treatment.

Patient signature Date

Patient name (print in full)

Physiotherapist signature Date

Physiotherapist name (print in full)