

## ACUPUNCTURE CONSENT FORM

Patient Information			
First Name	Last Name	Date of Birth	Gender
Street Address	City	State	Zip Code

Medical History
Please indicate all conditions that apply to you

I, the undersigned, hereby consent to the administration of acupuncture treatment by the licensed acupuncturist. I understand that acupuncture involves the insertion of thin needles into specific points on the body to promote healing and balance.

I am aware that the benefits of acupuncture may include relief of pain, stress reduction, and improved overall well-being. I understand that while uncommon, risks and side effects may include bruising, soreness, or infection at the needle site.

I understand that my personal and medical information will be kept confidential, except as required by law.

I have been informed of alternative treatments and their risks and benefits, and I have chosen acupuncture after considering these alternatives.

**Signature Date:**

**Signature:**