

## Information About Acupuncture Treatment

**Acupuncture** is a health care modality that involves the stimulation of specific points on the body. It has the effect of normalizing physiological function, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. The stimulation may be produced by needles, heat, manual pressure, electrical currents, or other means, but most frequently by needling. This clinic uses **single-use, sterilized, disposable needles** for each acupuncture treatment.

Acupuncture is considered a very safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts from a few minutes to a few days. There have been rare instances reported in which a patient fainted, developed a scar or infection, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung). This clinic takes many precautions to minimize the risk of adverse events.

**Herbs and nutritional supplements** may be prescribed and are considered safe in the practice of Chinese Medicine. Some herbs or supplements have an unpleasant taste, and some are contraindicated during pregnancy or for patients taking anticoagulants such as Warfarin (Coumadin). Discontinue taking and notify our office immediately if you experience nausea, gas, stomachache vomiting, headache, diarrhea, rashes, or tingling of the tongue. These are uncommon side effects associated with some products.

**Cupping** involves a localized suction produced by heating a small glass cup. Local bruising from the suction is likely, but bruises are rarely painful or uncomfortable. They typically resolve in 7-10 days or less.

### Consent for Acupuncture Treatment

I have read and understand the benefits and possible risks of treatment by acupuncture and use of Chinese herbal medicine to me. I understand that, as with all health care, no guarantee of results can be made. My questions have been answered and I wish to proceed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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*If this consent is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_