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:**