ACUPUNCTURE CONSENT FORM

“Acupuncture” means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of one’s symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

Please Note: The acupuncture treatment (which includes procedures described above) that you will receive today and in the future, at the Intern Clinic of the Eastern School of Acupuncture and Traditional Medicine, will be carried out by a student(s) in his/her third year of acupuncture training. This means that the student(s) treating you is NOT a licensed acupuncturist, and is not yet qualified to perform acupuncture treatments outside the Intern Clinic. However, the student(s) is closely supervised by an acupuncturist who is licensed to practice acupuncture in the state of New Jersey.

“With this knowledge, I voluntarily consent to the above procedures.”

____________________________________  __________________________________
Printed Name                  Patient Signature

____________________________________  __________________________________
Witness                      Date