**[INSERT STUDIO NAME] ACUPUNCTURE CLIENT CONSENT FORM**

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| **CLIENT DETAILS** |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PROCEDURE DETAILS** |
| Operator’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Site on body \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Type of acupuncture \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **CLIENT MEDICAL HISTORY**Do you (does the client, if completing for an under 16) currently suffer from, or have you (they) ever suffered from any of the following? |
|  | YES | NO | DETAILS |
| Heart condition / Angina |  |  |  |
| Blood pressure problems |  |  |  |
| Do you wear a pacemaker or any other electrical equipment? |  |  |  |
| Do you wear dentures / have a large amount of metalwork in your teeth? |  |  |  |
| Sinus problems / asthma |  |  |  |
| Epilepsy / Seizures |  |  |  |
| Haemophilia / Blood clotting disorders |  |  |  |
| Skin complaints e.g. psoriasis, eczema, dermatitis |  |  |  |
| Lumpy raised scars (keloid scars) |  |  |  |
| Diabetes |  |  |  |
| Allergic response e.g. anaesthetics, jewellery |  |  |  |
| Are you prone to fainting attacks? |  |  |  |
| Do you regularly take any blood-thinning medicines e.g. aspirin? |  |  |  |
| Do you take any regularly prescribed medication? |  |  |  |
| Could you be pregnant? |  |  |  |
| Any other associated condition(s)? |  |  |  |
| Details of any associated problems with treatment |  |  |  |
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| I declare that the information I have provided on medical history is correct to the best of my knowledge and that I am not currently under the influence of drugs or alcohol. I hereby give consent for the acupuncture detailed above to be carried out by the named operator. I confirm that I have been provided with written information on (i) the potential complications associated with the procedure and (ii) appropriate aftercare advice for the acupuncture. I agree that it is my responsibility to read this and the aftercare advice and follow the instructions on it until the treatment area is healed. I give consent to the operator to retain the details provided on this form for a period of 2 years from today.Client signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Operator signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_ |

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| Where the client is under 16 years old, details and consent of parent or guardian: |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Proof of ID provided? YES / NO |
| Parent/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Operator signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |