

Informed Consent to Acupuncture/Massage/

Herbal & Nutritional Therapy

I hereby request and consent to the performance of Acupuncture/Massage/Chinese Herbal therapy/ Nutritional counseling on me by the Acupuncturist working in this clinic below. I understand that Acupuncture/Massage/Chinese Herbal therapy/Nutritional counseling involves the use of disposable sterile needles being inserted into the skin at various places on the body, application of pressure on pressure points, and or use of herbal and health food supplements in order to treat a wide variety of conditions for therapeutic purposes.

I also understand that some of the possible side effects of acupuncture therapy and massage may include drowsiness, euphoria, dizziness, temporary muscle aches and bruising, and that those associated with herbal and nutritional supplements may be similar to any allergic reaction commonly seen with any foods consumed as part of a regular diet.

I also understand that it may take more than one treatment before any noticeable effects are achieved and I agree to cooperate with the therapist with regards to the treatment being given.

I have stated all my known medical conditions and take it upon myself to keep the Acupuncturist updated on my physical health.

To be completed by the patient:

PRINT PATIENT'S NAME
(PARENT/GUARDIAN)

SIGNATURE OF PATIENT

WITNESS TO SIGNATURE ABOVE

DATE SIGNED



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