**FOOTHILLS CHIROPRACTIC HEALTH CENTER**

# Acupuncture Treatment Consent

I, the undersigned, do hereby give my voluntary consent for the administration of acupuncture.

I have been made aware of the possibility of complications which may result from these procedures. These include; infection(rare), bruising and bleeding into the tissues, pain and discomfort, weakness, tiredness, fainting, nausea, aggravation of existing symptoms for a short time, etc.

I state that I do not have the following conditions:

- Pregnancy
- Bleeding disorders
- A pacemaker
- Local infections
- Anticoagulants

If I have any of the above conditions, I have listed them here:

_____.

I hereby certify that I have read and understood the above authorization and the risks involved. All relevant questions which I have asked have been answered.

_____ _____

Print Patient Name Patient Signature

_____

Date Signed