EnWell Chiropractic & Acupuncture

Informed Consent for Acupuncture

I hereby volunteer consent to receiving acupuncture and Oriental Medicine Treatment for my present and future health conditions. I understand the treatment will be administered by EnWell Chiropractic & Acupuncture.

Acupuncture and Oriental medicine treatments that may be administered:

Acupuncture: this is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness. Other possible risks in acupuncture include dizziness and fainting. I will report to the doctor any dizziness or light headedness that occurs during and/ or after an acupuncture treatment. Rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) including fainting, nerve damage, organ puncture (pneumothorax) and infection.

Traditional Chinese herbal supplements: Chinese herbs have been used safely for centuries infrequently, one may experience digestive upset or other reactions to the herbs. If I experience any discomforts related to the use of herbal, I understand that I should stop the herbs and that I am responsible for informing the doctor of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the doctor of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP/Infrared lamp: This is used to warm an area of the body. Every precaution is taken to prevent overwarming, but the rare possibility of a mild burns exists.

Moxibustion Treatment: Moxibustion is the burning of an herb (Moxa AKA mug wart) which produces heat. There are many forms of moxa. The herb burns on the handle of the needle, in a “moxa box”, applied to the skin over salt or ginger, waved over the skin, etc. There is risk, however small, of being burned direct by a form of moxa being used or by the ash falling on the skin.

Cupping: Cupping is a treatment of creating a vacuum in glass or plastic cup, which is applied to the surface of the skin. After the cups are removed there may be a slight discoloration of the skin (like a type of bruising) this usually will resolve in a few days to a week. Very rarely a slight burn or blister may appear due to the heat and or suction.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth edged instrument. This often results in bruising at the treatment area. The bruising which is usually not painful usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro current (similar to TENSE treatment) is used to stimulate acupuncture needles. A mild tingling or tapping sensation may be felt. This is only raised to the level of patient comfort.

Tui Na: a form of massage based of Chinese medicine principles it often includes the use of liniments, oils, or creams. There is a possibility of an allergic reaction to these and the practitioner will ask you before using them, other risks with Tui Na may include soreness post treatment, bruising and or increased pain.

I understand that no promise has been made regarding the outcome of treatment and that reasonable efforts will be made to give information to me so that I might make an educated decision regarding the duration and the appropriateness of continued care. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which he feels at the time, based upon the facts then known, and is in my best interests.

I have read or have read to me the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss this consent with the doctor. I understand I can request more information at any time if desired. I consent to receiving treatment that involves the above procedures. I understand that I have the rights to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Patient Name (Please Print) _____ Date: _____

Patient/Guardian Signature _____

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to berelated in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: