- St. Albert Physical Therapy & Sports Injury Clinic Inc
- Dynamic Sports Physiotherapy
- Kensington Physical Therapy & Sports Injury Clinic
- Fort Physical Therapy & Sports Injury Clinic

Inform Consent for Needling Techniques

I, the undersigned, do hereby give my voluntary informed consent for the administration to me of medial acupuncture and other relevant traditional Chinese medical therapies and/or Intramuscular Therapy. These techniques are to be applied by or under the direction and supervision of a Physical Therapist or Acupuncturist.

Acupuncture/IMS has been explained to me as a medical treatment performed by the insertion of special sterilized needles (with or without the application of small pulses of electrical current to needles) through the surface of the body for the purposes of the alleviation of pain or treatment of bodily diseases for an undetermined time. Alternate methods include surgical and/or other medical treatments.

I have been made aware of the possibility of complications that may result from this procedure. These include (but are not limited to), pain, discomfort, weakness, fainting, nausea, needle retention, and even aggravation of symptoms existing prior to acupuncture treatment. Any time a needle is used, there is risk of infection. We use new disposable sterile needles and infection is rare. A needle may be placed inadvertently in an artery, vein or nerve. If an artery or vein is punctured, a hematoma or bruise will develop. If a nerve is punctured, it may cause paraesthesia (a prickling sensation) which may continue for days. When a needle is place closed to the chest wall, there is a rare possibility of ta pneumothorax (air in the chest cavity). Fortunately these complications are rare and reversible. It is normal specifically after IMS therapy to experience a substantial ache for a period of a few hours to a few days, followed by an overall improvement in pain state.

I am aware that the use of acupuncture to which I am consenting is not a common practice in this community. I am aware that I may withdraw this consent and stop treatment at any time.

I hereby certify that I understand the above authorization and the risks of possible complications. All relevant questions, which I have asked, have been answered by my therapist.

Signature of Patient: _____

Name of Patient (Print):_____

Date (mm/dd/yy) ____/_____ /20____

Signature of Witness: _____

Witness Name (print): _____