CONSENT FOR DRY NEEDLING

PLEASE READ THIS FORM CAREFULLY

1. You have been diagnosed as having a muscle disorder that might benefit from dry needling therapy. Research and practice shows that dry needling can lessen muscle pain and reduce muscle tension. Dry needling therapy is not acupuncture, but is similar to it in the sense that needles are introduced into the tissues for therapeutic reasons. The physical therapist will be inserting needles in places in your muscles that are causing your discomfort (trigger points), not in areas that are far away from your pain or on your ear.

2. You will receive dry needling treatment from a physical therapist who has met the requirements of the State Board of Physical Therapy totaling a minimum of 50 hours of directly supervised training and is credentialed by the State Board to perform this procedure.

3. THE POSSIBLE RISKS OF DRY NEEDLING INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING: PUNCTURED LUNGS, BRUISING, INFECTION, EXTENDED OR TEMPORARY NERVE INJURY, TEMPORARY MUSCLE SORENESS, OR INJURY TO BLOOD VESSELS CAUSING A POOLING OF BLOOD IN YOUR TISSUES.

4. Alternative therapies that could be used instead of dry needling include, but are not limited to the following: traditional physical therapy techniques such as manual therapy, ultrasound, electrical stimulation, therapeutic activities, neuromuscular re-education and therapeutic exercise.

5. I HAVE READ OR BEEN READ THE ABOVE INFORMATION. THE NATURE AND PURPOSE OF THE PROCEDURE, POSSIBLE ALTERNATIVE METHODS OF TREATMENT, RISKS INVOLVED, AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN FULLY EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS I HAVE ABOUT DRY NEEDLING. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED. I HEREBY AUTHORIZE MY PHYSICAL THERAPIST(S) TO PROVIDE ME WITH DRY NEEDLING THERAPY.

Signed ______________________ Relationship: _________ Date: ________ Time: ________

I have explained the dry needling procedure to this patient or this patient’s relative including its anticipated benefits, potential risks or complications, and available alternatives.

Therapist: _______________________________________ Date: _________ Time: __________