PALMS
ACUPUNCTURE
&
WELLNESS
JUPITER FLORIDA

Injection Consent

NAME _____ DATE OF BIRTH _____ AGE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHO MAY WE THANK FOR REFERRING YOU? _____

EMAIL ADDRESS _____
MAY WE EMAIL YOU SPECIALS? ◯ YES ◯ NO

EMERGENCY CONTACT _____ PHONE _____

LIST ALL MEDICATIONS AND / OR SUPPLEMENTS, INCLUDING HERBS AND VITAMINS YOU ARE CURRENTLY TAKING (FEEL FREE TO BRING A COPY OF YOUR MEDICATION LIST TO YOUR APPOINTMENT)

ARE YOU CURRENTLY ILL WITH A COLD OR THE FLU? ◯ YES ◯ NO
ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ◯ YES ◯ NO
HAVE YOU PREVIOUSLY HAD AN INJECTION? ◯ YES ◯ NO

I AM REQUESTING AN INJECTION.

I UNDERSTAND WITH ALL INJECTIONS, THEY MAY CAUSE PAIN OR REDNESS AT THE SITE OF INJECTION ALTHOUGH THIS IS RARE. SOMETIMES YOU MAY ALSO BRUISE AT THE SITE OF INJECTION. IF YOU HAVE ANY CONCERNS AFTER THE INJECTION WITH SWELLING OR REDNESS, PLEASE CALL THE OFFICE IMMEDIATELY. IF IT IS AFTER HOURS, PLEASE GO TO THE EMERGENCY ROOM IF YOU ARE HAVING DIFFICULTY BREATHING OR ANY OTHER SERIOUS REACTIONS.

I CERTIFY THAT EVERYTHING ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE _____ DATE _____

ACUPUNCTURIST SIGNATURE _____ DATE _____
DENISE JACOBS, DOM