Dry Needling Consent Form

Name: _____ **Date of Birth:** _____

Consent for Dry Needling Treatment:

I, the undersigned, hereby consent to the administration of Dry Needling therapy by Everwell PT during the current visit and any subsequent visits as deemed necessary by my physical therapist.

Understanding Dry Needling:

Dry Needling is a therapeutic technique employed by physical therapists to alleviate musculoskeletal pain and dysfunction. It involves the insertion of thin, sterile, monofilament needles into specific points within the muscles, known as trigger points, without the injection of any substances. The primary goal is to release muscle tension, improve blood flow, and promote the body's natural healing processes. This technique is often utilized to address conditions such as muscle tightness, spasms, and pain patterns, thereby enhancing overall functional movement and reducing discomfort.

Potential Risks and Side Effects:

While Dry Needling is generally considered safe, it is important to be aware of potential risks and side effects, which may include:

- **Temporary Soreness or Bruising:** Mild discomfort or bruising at the needle insertion sites, typically resolving within a few days.
- **Bleeding:** Minor bleeding may occur at the insertion points.
- **Infection:** Although rare due to the use of sterile needles, there is a minimal risk of infection.
- **Nerve or Blood Vessel Injury:** Uncommon but possible, leading to pain, numbness, or tingling.
- **Pneumothorax:** A rare complication involving the collapse of a lung, particularly when needling near the chest area.

I acknowledge that I have read and understood the above information regarding Dry Needling therapy, including its purpose and potential risks. I have had the opportunity to ask questions and have received satisfactory answers. By signing below, I consent to the performance of Dry Needling by Everwell PT as part of my treatment plan.

Questions:

Are you currently talking any antibiotics for infection? [**Yes**] or [**No**]

Are you currently pregnant? [**Yes**] or [**No**]

Do you have any metal allergies? [**Yes**] or [**No**]

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

**Note: This consent form will be maintained as part of your confidential medical record.*