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## Informed Consent for Dry Needling of Trigger Points

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Your physical therapist has recommended that you receive Dry Needling technique for the evaluations and treatment of myofascial trigger points and tender points within your muscles, tendons or ligaments. Recent evidence has shown that trigger points are localized areas of hyperactive muscle or tissue that have numerous inflammatory and pain producing chemicals causing local tightness of the muscle. The tightness of the muscle is often accompanied by pain and dysfunction of the muscle, consequently irritating local nerve endings as well as decreasing normal movement of the nearby joints enough to limit normal functional activities.

Dry needling to trigger points has been shown to decrease or completely reduce the irritation and to reduce or completely eliminate the irritating chemicals in an active trigger point. This release can immediately improve range of motion, decrease pain and improve function. Patients often feel a significant improvement of their symptoms immediately after the treatment. Trigger point dry needling facilitates a hastened return to strengthening and exercises that result in a faster return to function.

The dry needling procedure involves placing a very thin, single use disposable sterile solid filament needle (not hollow) with sterile technique into a trigger point. The number of needles used during any individual visit and the number of visits you are given this treatment depends on many factors that differ from patient to patient. **THIS IS NOT ACUPUNCTURE; NOR IS THIS ANY FORM OF ACUPUNCTURE.**

Be assured that this procedure is very safe. Most patients do not feel the needle when it is placed and other than a focal muscle twitch or feeling of a subtle muscle cramp around the needle tip, there is little to no pain with this procedure. Because the needle being used is very thin, there is usually little to no bleeding with this procedure. Occasionally, however, complications may arise. Any procedure intended to help may have complications or side effects. While the chances of experiencing complications are unlikely, it is practice of Dubuque Physical Therapy to inform our patients about them. Most of these complications are very minor and self-limiting and resolve rapidly.

**Minor complications include:**

- Focal bruising at the needle insertion site.
- Minor soreness in the immediate area afterward.
- A small amount of bleeding at the needle insertion site that stops on its own within a few minutes.
- These minor complications generally resolve within a day or two after the treatment.

**More serious complications, while very rare, are possible and include:**

- Fainting
- Persistent bleeding at the needle insertion site.
- Infection
- Puncture of the lung (only if the needle is being used near lung tissue)

The possibility of complications may be increased if you have certain pre-existing problems. It is very important that you discuss with your physical therapist any problems that you have had, currently have, or might have. Specifically:

\_\_\_\_\_ I have a fear of needles, I have fainted, or fear I will faint when needles have been used for my diagnosis or care in the past.

\_\_\_\_\_ I have a bleeding disorder that causes my blood to clot slowly or not at all.

Please specify \_\_\_\_\_

\_\_\_\_\_ I have a history of a blood disorder that can be transmitted to another person.

Please specify \_\_\_\_\_

\_\_\_\_\_ I take blood thinners (anti-coagulation) medication.

Please specify \_\_\_\_\_

\_\_\_\_\_ I have taken pain relievers (e.g. aspirin, etc.) in the past 48 hours.

Please specify \_\_\_\_\_

\_\_\_\_\_ I have an artificial implant (pacemaker, silicone, insulin pumps, etc.)

Please specify \_\_\_\_\_

I have read this Patient Information and Consent carefully, **I understand this procedure is not acupuncture** and have an opportunity to ask questions and obtain any desired clarification. I also understand there is no guarantee or warranty for a specific cure or result. I understand the above statements regarding examination and treatment side effects. I give my permission and consent to the procedure or treatment. I understand that I can stop this procedure at any time.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If patient is less than 18 years of age a parent or legal guardian must sign.**

Name of Parent/Legal Guardian (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_