SHIRODHARA THERAPY PATIENT CONSENT FORM

Clinic Name: _____ **Date:** _____

Doctor Name: _____

Patient Name: _____

Consent to Undergo Shirodhara Therapy

I, the undersigned, hereby consent to undergo Shirodhara therapy as part of my Ayurvedic treatment at the above-mentioned clinic. I understand that this procedure involves the application of a continuous stream of warm herbal oil or other therapeutic liquids on my forehead.

Acknowledgment of Information

1. **Therapy Purpose:**
   - I understand that Shirodhara is a relaxation and rejuvenation therapy aimed at promoting mental clarity, reducing stress, and balancing the nervous system.
2. **Procedure and Potential Benefits:**
   - I have been informed about the procedure, its potential benefits (e.g., stress relief, improved sleep, and mental calmness), and its role in maintaining overall wellness.
3. **Possible Risks and Side Effects:**
   - I am aware of possible side effects, such as mild headache, temporary dizziness, or oil sensitivity, and understand that these are generally rare and temporary.
4. **Precautions Taken:**
   - I have disclosed all relevant medical information, including any allergies, skin conditions, or other health concerns, to the attending doctor.
5. **Voluntary Participation:**
   - I confirm that I am undergoing Shirodhara therapy voluntarily and understand that I may discontinue the session at any time.

Declaration

By signing below, I acknowledge that I have read and understood the information provided about the Shirodhara therapy. I have had the opportunity to ask questions, and my concerns have been addressed to my satisfaction. I consent to receive the therapy under the care of the attending doctor at the above-mentioned clinic.

Patient Signature: _____

Date: _____

Doctor Signature: _____

Date: _____

Witness (if applicable): _____

Date: _____