INFORMED CONSENT TO CHIROPRACTIC CARE

Keith C. Winkleblech, D.C.

893 Henderson Avenue
Washington, PA 15301
Telephone: (724) 223-0590

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though Chiropractic/Pro-Adjuster adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment: Please initial beside any physio modality of concern to you.

_____	Heat:	1st and 2nd degree burns: hemorrhage
_____	IST:	Aggravation of present conditions
_____	Ice:	Skin Reactions
_____	Ultrasound:	Periosteal burns; Skin reaction; Dissemination of unknown infection
_____	Flexion-Distraction Therapy:	Aggravation of present conditions
_____	Electric Muscle Stimulation:	Burns; Electric shock; Skin reaction; spread of unknown infection or cancer; interference with blood pressure if treated in cervical region
_____	Trigger Point Therapy:	Bruising; Release of emboli
_____	Massage:	Aggravation of present conditions; Skin irritation; Deep vein thrombosis

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian_____ Date_____
(If patient is a minor)

Witness Signature_____ Date_____

Doctor's Signature_____ Date_____