INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

This notice is to advise you that every type of health care delivery system, including chiropractic care, has associated risks and the potential for complications. While we are committed to providing you with the best and safest treatment possible, we also have a legal and moral responsibility to advise you about some rare but possible problems that can occur with chiropractic care and/or physiotherapy.
Details of possible complications:

TEMPORARY SORENESS: Chiropractic adjustment, traction, massage, stretching, exercise, etc. all have the capability of causing temporary soreness. This typically lasts 6-24 hours.
SOFT TISSUE REACTIONS: This term refers to muscles; tendons; ligaments; cartilage; blood vessels; nerves; scar tissue, adhesions and other connective tissue. At times, these tissues may be stretched or irritated, resulting in pain.
BRUISING: Bruising is most commonly seen in patients with hemophilia, leukemia, liver cirrhosis, sepsis and those on blood thinning medications. Bruising may also occur as a result of deep tissue massage therapy.
BURNS: Some physiotherapy equipment and/or modalities, i.e. hot packs, ice, ultrasound, diathermy and electrical stimulation, work in part by generating heat or cold. It is possible for a patient to be burned by heat or ice. Usually, these are minor problems but they can cause temporary redness, mild swelling or pain for a few days.
FRACTURES: Rarely chiropractic adjustments may result in a fracture. Again, this is very rare but is most commonly seen in the ribs. The risk is increased in the elderly osteoporotic patient. We adjust all of our patients carefully - especially our older patients to minimize this risk!
DISC INJURIES: Non-surgical disc injuries are frequently and successfully treated by skilled chiropractors. Occasionally, chiropractic treatment may aggravate a preexisting disc problem. This is most common when the disc is inflamed or severely damaged prior to the initiation of treatment.
CEREBROVASCULAR ACCIDENTS including but not limited to stroke: This is a controversial issue. Two retrospective studies reviewed 10 million neck adjustments over a 15 year period and found NO evidence of stroke or other serious adverse events. Based on nine major research studies it appears that the probability of having a serious adverse reaction is 0.8 per 1 million neck adjustments. In comparison, two studies found that the risk of spontaneous stroke in the general population is about 20 per 1 million people. That means that any individual is 25 times more likely to have a stroke due to their normal daily activities than as a result of chiropractic care.
UNFORESEEN COMPLICATIONS/OTHER PROBLEMS: There may be problems or complications that arise from chiropractic treatment or physiotherapy other than those described herein. These occur so infrequently that it is not possible to anticipate them, predict them, or explain them all in advance of starting treatment. If any problem begins to develop, please advise the doctor immediately.

In order to minimize your risk it is extremely important for you to inform the doctor of any serious medical conditions or change in your health status.

ACKNOWLEDGEMENT

I do not expect the doctor to be able to anticipate all risks and complications. I do wish to rely on the doctor to exercise their clinical judgment during the course of treatment for which they feel, based upon the facts known at that time, to be in my best interest.

I hereby request and consent to the performance of chiropractic manipulative therapy also known as adjustments as well as any other chiropractic procedures, including examination tests, diagnostic X-rays and physiotherapy techniques, on me (or on the patient named below, for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who are now or in the future render treatment to me while employed by, working for, associated with, or serving as back-up for the doctor of chiropractic named below.

I have discussed, with the doctor named below, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

(Check one) I have read __ ; or have had read to me__ the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

TO BE COMPLETED BY PATIENT

Patient's Name _____ Date Signed _____
PLEASE PRINT

Signature of Patient _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name _____ Name of Representative _____
PLEASE PRINT PLEASE PRINT

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

TO BE COMPLETED BY DOCTOR

Based on my personal observation as well as the patient's history and physical exam, I conclude that throughout the informed consent process the patient/guardian/representative was:

[ ] Of legal age and of sufficient capacity **OR** [ ] Consent given through Guardian/Representative

[ ] Oriented x3

[ ] Appears unimpaired

[ ] Fluent in English **OR** [ ] Assisted by a translator or interpreter:

Translator Name _____ Date_____

Translator Signature _____

Name of Doctor treating this patient:_____,D.C. Date_____

Signature of Doctor _____