

**Informed Consent**

Todd W Just, DC, ART  
Chiropractor

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

I hereby request and consent to the performance of chiropractic adjustments, also known as spinal manipulation and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Just.

I have had the opportunity to discuss with the doctor the purpose and planned treatment and potential benefits as well as the risks of the proposed treatments. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand that there are some side effects or risks associated with treatment. These side effects might include mild to moderate increased pain and soreness in the area of treatment or other areas, headache, and fatigue. Nausea, dizziness, or other reactions are rarely reported. A specific side effect of Active Release Technique (ART) is redness and bruising (very rare) in the area of treatment, possible soreness and possible temporary increase in pain and symptoms.

A rare but serious risk associated with neck manipulation is stroke. Other serious risks include, but are not limited to fractures, disc injuries, dislocations and sprains.

I understand that the practice of chiropractic is not an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he feels at the time, based upon the facts known, is in my best interests.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the chiropractic treatment described to me by the doctor.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_