connect
CHIROPRACTIC
& WELLNESS

Informed Consent to Treatment
Chiropractic & Massage

Please read and sign the following in order to completely understand the risks and benefits of your care.

I _____ (Patient's or Legal Guardian) hereby request and consent to the performance of chiropractic adjustments, and any other chiropractic or massage procedures, including examination tests and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the licensed doctors of chiropractic at this office.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. For chiropractic, complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, cervical myelopathy and costovertebral strains and separations, and increase in symptomatology. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I acknowledge that, although doctors of chiropractic are experts in the analysis of musculoskeletal conditions and their effects on the nervous system, they are not internal medical specialists. I take responsibility in being mindful of my own symptoms and should secure other opinions should I have any concerns as to the nature of my total condition. The licensed doctors of chiropractic may express an opinion as to whether or not I should take this step, but I am responsible for the final decision.

I have had an opportunity to discuss with the doctor named below and/or with office personnel 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.

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

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed name of Patient_____ **Date**_____

Signature of Patient or Legal Guardian_____ **Date**_____

Doctors' / Witness Signature_____ **Date**_____