

## Informed Consent for Chiropractic Treatment

**TO THE PATIENT:** You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- |   |   |
|---|---|
| <input type="checkbox"/> Broken bones                               | <input type="checkbox"/> increased symptoms and pain        |
| <input type="checkbox"/> Dislocations                               | <input type="checkbox"/> No improvement of symptoms or pain |
| <input type="checkbox"/> Sprains/strains                            | <input type="checkbox"/> Infection (acupuncture)            |
| <input type="checkbox"/> Burns or frostbite (physical therapy)      | <input type="checkbox"/> Punctured lung (acupuncture)       |
| <input type="checkbox"/> Worsening/aggravation of spinal conditions | <input type="checkbox"/> Other _____                        |

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

*To be completed by the patient:*

\_\_\_\_\_   
print name

\_\_\_\_\_   
signature of patient

\_\_\_\_\_   
date signed

*To be completed by the patient's representative:*

\_\_\_\_\_   
print name of patient

\_\_\_\_\_   
print name of patient's representative

\_\_\_\_\_   
signature of patient's representative

as: \_\_\_\_\_   
relationship/authority of patient's representative

\_\_\_\_\_   
date signed

*To be completed by doctor or staff:*

\_\_\_\_\_   
witness to patient's signature

\_\_\_\_\_   
date

\_\_\_\_\_   
date