

Informed Consent to Chiropractic Treatment

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risk associated with such treatment. In particular you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament strains or sprains following spinal adjustments;
- b) There have been reported cases of injury to a vertebral artery following cervical spine adjustments. vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasions result in serious injury. The possibility of such injury resulting from cervical spinal adjustment is extremely remote;
- c) There have been rare reported cases of disk injury following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injury or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I hereby request and consent to the performance of chiropractic examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20____

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)