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Chiropractic consent form

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____ consent to examination and to the performance of conservative noninvasive treatments for my conditions. I understand that the procedures may consist of manipulation involving movement of my joints and soft tissues along with physical therapy modalities and rehabilitative exercises.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which are as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Joint injuries: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be employed.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Strokes: Although strokes happen with some frequency in our world. Strokes from chiropractic manipulation are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests have been performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume the risks. I also understand that there are beneficial effects associated with these treatment procedures including decreasing pain, reduced muscle spasm, increased mobility,

and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of procedures.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

_____ Signature of Patient

_____ Signature of legal guardian for minor

_____ Signature of Witness

_____ Signature of Doctor

_____ Date

Doctors Notes- of legal age_____ oriented x 3_____ unimpaired_____
Assisted in understanding by interpreter_____