Informed Consent for Chiropractic

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything needs clarification, please ask before your sign it.

The nature of the chiropractic adjustment. The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I understand that the chiropractor will use that procedure to treat me. I understand that the chiropractor may use their hands or a mechanical instrument upon my body in such a way as to move my joints. That may cause an audible “pop” or “click,” such as most have experienced when they “crack” their knuckles. I may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, I am consenting to the following procedures:

spinal manipulative therapy	palpation
vital signs	range of motion testing
orthopedic testing	basic neurological testing
muscle strength testing	postural analysis testing
ultrasound therapy	hot/cold therapy
EMS unattended	EMS attended (rapid release therapy)
physiotherapy	radiographic studies

Any other (please explain)

_____

_____

Treatments I’m **not** consenting to: _____

I understand that there are risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, bruises, costovertebral strains and separations, and burns. 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 understand that some patients including myself will feel some stiffness and soreness following the first few days of treatment. I understand that the doctor will make every reasonable effort during the examination to screen for contraindications to care. If I have a condition that would otherwise not come to the doctor’s attention, it is my responsibility to inform the doctor.

Fractures are rare occurrences and generally result from some underlying weakness of the bone. The doctor will check for fractures when taking your history, during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options.

Other treatment options for my condition may include:

• Self-administered, over-the-counter analgesics and rest

• Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers

• Hospitalization

• Surgery

I understand that if I choose to use one of the “other treatment” options noted above, I should be aware that there are risks and benefits of such options and I may wish to discuss these with my primary medical physician.

The risks and dangers of remaining untreated.

I understand that remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

All information will be kept strictly confidential and will remain with Frontier Chiropractic. I have read and agree with all the information. If I have any questions or concerns, I will ask the chiropractor or staff.

By signing below, I show that I have read, or have had read to me, the above consent to treatment and have been told the risks and benefits of chiropractic and other procedures and practices involved, and have had the opportunity to ask questions.

Patient Name (printed): _____ Dated: _____

Patient Signature: _____

Parent or Guardian Name (printed): _____ Dated: _____

Parent or Guardian Signature (if a minor) _____