

Informed Consent

Patient Name: _____

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

The primary treatment used by doctors of Chiropractic is the **Chiropractic adjustment**. We will use this procedure to treat you. We may use our hands or a mechanical instrument in such a way as to move your joints. That may cause an audible “pop,” similar to popping your knuckles. You may feel a sense of movement.

As a part of the **analysis, examination, and treatment**, you are consenting to: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies.

Possible risks with chiropractic adjustments. As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains 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. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial 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 arterial stroke.

The availability and nature of other treatment options may include: Self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization or surgery. If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers to remaining untreated: 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.

Consent to Treatment (Minor)

I hereby request and authorize Paul Graves, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child or minor I am legal guardian of. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor’s discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of the spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient’s Name: _____ Date: _____

Signature: _____

Signature of Parent/Guardian (if a minor): _____