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INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

Date: _____

Patient Name: _____

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I will call the doctor immediately. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and, if necessary, diagnostic x-rays, on me by the doctor and/or any of his qualified staff.

I have had the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures relative to my care. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks with treatment, including, but not limited to muscle strain and sprain, disc injury and cerebrovascular accident. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise his best judgment during the course of the procedure which, based upon the facts then known, the doctor feels at the time is in my best interest.

_____	_____	_____
Patient Signature	Date	Staff Signature

_____
Parent/Guardian Signature