INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your clinician if you would like and then sign where indicated at the bottom. Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation and mobilization, are required to inform patients that there are or may be some risks associated with such treatment. In particular:

a. While extremely rare, some patients experience muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.
b. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
c. There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused or may be caused by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been subject of much research conducted over many ears and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulder/arms/legs, headaches and other symptoms. Treatment provided at this clinic may also contribute to your overall well being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment is particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joint of my spine, pelvis and extremities as needed and I intend this consent to apply to all my present and future treatments at this clinic.

Patient Signature	Printed Patient Name
Signature of Guardian (when applicable)	Printed Guardian Name
Signature of Witness/Translator	Printed Witness/Translator Name

Date: _____