

# INFORMED CONSENT

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

I \_\_\_\_\_, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Rehabilitative exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness/Bruising:** I am aware that, like exercise, it is common to experience muscle soreness and occasional bruising in the first few treatments.

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

**Fractures/Joint Injury:** I further understand that in isolated cases, underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I'm aware that nerve or brain damage including stroke is reported to occur 1-in-a-million to 1-in-10-million treatments. 1-in a million is about the same chance as getting hit by lightning. 1-in-10 million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been/will be performed to minimize risk of any complication from treatment. I freely assume these risks

## TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including: decreased pain, improved mobility/function, & reduced muscle spasm. However, I appreciate there is no certainty I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other individuals of the doctor's choosing.

## ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I'm aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapies and exercises. Prolonged bed rest contributes to weakened bones, joint stiffness and atrophy to muscles. Exercises are of limited value but are not corrective to injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for joint instability, pathology, or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-treatment:** I understand potential risks of refusing/neglecting care may include: increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery & rehabilitation more difficult & lengthy.

----- *I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.*

----- To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

(if patient is a minor)

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_