



**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment**

As a part of the analysis, examination and treatment you are consenting to the following procedures:

- |                                    |                             |                             |
|------------------------------------|-----------------------------|-----------------------------|
| <b>Spinal manipulative therapy</b> | <b>Ultrasound</b>           | <b>Hot/cold packs</b>       |
| <b>Radiographic studies</b>        | <b>Interferential</b>       | <b>Physical examination</b> |
| <b>Intersegmental traction</b>     | <b>Diatherm</b>             | <b>Myofascial release</b>   |
| <b>Percussion massage</b>          | <b>Therapeutic exercise</b> |                             |

**Other:** \_\_\_\_\_

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**The material 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: muscle strain, joint sprain and costovertebral strains. Some patients will feel some stiffness and soreness following the first few days of treatment. However, complications are generally rare. I 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 my attention, it is your responsibility to inform me.

**The availability and nature of other treatment options**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers

- Hospitalization
- 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 risk and dangers attendant to remaining untreated**

Remaining untreated may allow the formation of adhesion 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 UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLANK 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 Dr. Roberts 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 my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.**

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Doctor's Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Signature of Parent or Guardian (If minor)