



Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, massage, acupuncture or rehabilitative stretch/strengthening exercises may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritations, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “extremely rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in one million to one in twenty million, we will make every reasonable effort during examination to screen for contraindications to care. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other Treatment Options (not provided by this clinic): May include: over-the-counter NSAID’s, prescription medication, steroid and other injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I understand that the practice of chiropractic, like the practice of any healing art, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcomes of my care.

I have read the explanation above of chiropractic treatment at Chiropractic CareCentre. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Consent to Treat Minor - For use when applicable

I hereby authorize Chiropractic CareCentre doctors of chiropractic to perform examination, administer chiropractic care, including adjustments, and other treatments or modalities as deemed necessary, to my child.

_____	_____	_____
Name of Child	Signature (Parent of Guardian)	Date