# INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

## DR. KEVIN T. O'HARA, D.C.

I hereby request and consent to the chiropractic services of Kevin O'Hara, D.C., associated licensed doctors, and/or authorized persons who might now or in the future treat me while employed by, working or associated with, or serving as a back-up for Kevin O'Hara, D.C. in an attempt to improve my physical condition.

I understand the purpose of this and subsequent visits are to acquire chiropractic care. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. Chiropractic care utilizes manipulation or joint adjustments, exercise, nutrition, and various modes of physiotherapy.

Although spinal 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 including, but not limited to: sprains, dislocations, fractures, disc injuries, strokes, and paralysis. I do not expect Dr. O'Hara to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on his judgment during the course of the procedures, which he feels is in my current best interests.

The nervous and musculoskeletal systems' reaction to Dr. O'Hara's chiropractic treatments may be a generalized soreness over and around the area of my chief complaint. This is a normal and expected result because the muscles in the area have been stressed (spasm) and the bones misaligned. During my treatment, Dr. O'Hara will be releasing stress on my spine, bones, joints, and surrounding soft tissues (e.g. muscles, tendons, ligaments, bursae, and nerves). This process breaks up the pain and spasm cycle in my body, but in doing so my body may require time to adapt to these physiological changes.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. O'Hara of any unusual symptoms that might occur. If during the course of care non-chiropractic or unusual findings are encountered, Dr. O'Hara will advise me of those findings and recommend that I seek the services of another health care provider

In signing this informed consent form, I affirm that I have read this form in its entirety and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic treatment, the management of my case, and the related risks to chiropractic treatment have been answered to my satisfaction.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

| NAME | SIGNATURE | DATE |
|---|---|---|
| _____ | _____ | _____ |
| _____ (SIGNATURE OF GUARDIAN/REPRESENTATIVE) | _____ (RELATIONSHIP TO PATIENT) | _____ |
| _____ O'HARA FAMILY CHIROPRACTIC REPRESENTATIVE | _____ | _____ |