Welcome to our office!

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, electric muscle stimulation, therapeutic ultrasound, traction, passive and active exercise may also be used.

Probability of risks occurring: The risks of complication due to chiropractic treatment have been described as *"rare"*, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered *"rare"*.

Other treatment options which could be considered may include the following:

- *Over the counter analgesics:* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects.

- *Medical care:* Typically anti-inflammatory prescriptions, muscle relaxers, and analgesics. Risks of these drugs include gastrointestinal irritation, long term use leads to liver and kidney disease as well as other side effects and dependence in a significant number of cases.

- Surgery in conjunction with medical care adds risks of infection and adverse reaction to anesthesia as well as extended convalescent period in a significant number of cases.

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.

Unusual Risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. 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.

Patient Name :_____ **Date**:_____

Signature:_____

CONSENT FORM

Name:_____ Gender:_____

Date of Birth:_____

Address:_____

Phone Number:_____

Email_____

Occupation:_____ Referral:_____

PATIENT COMPLAINT

What brings you in today?_____

_____

How/When did this occur?_____

_____

On a scale of 1 to 10 what is your level of pain? 1 2 3 4 5 6 7 8 9 10
(1-being in no pain 10- being in unbearable pain)

Describe your pain (stabbing, throbbing, radiating, etc)_____

_____

How frequent is your pain?_____

Have you experienced this in the past?_____

How is this complaint impacting your life?_____

_____

Have you done or received any treatment for this?_____

Any additional complaints?_____

PATIENT HISTORY

Have you had any accidents?(sports, car accidents, slips/falls)_____

Have you had any surgeries/hospitalizations?_____

Do you take any medications?_____

Do you take any supplements?_____

Any Tobacco/Drug use?_____ If yes, how often?_____

Exercise/Water/Diet Regime?_____

Any family history of health conditions?_____

Are you experiencing or have a history of any of the following conditions?

Neurological: ◯Dizziness ◯Nausea ◯Headaches ◯None

Cardiovascular: ◯Pain in the chest ◯Irregular Heart rate ◯None

Respiratory: ◯Trouble Breathing ◯Shortness of Breath ◯None

Digestive: ◯Change in Bowel Movement/Color ◯None

Skin: ◯Rash ◯Swelling ◯Bruising ◯Bumps ◯Lumps ◯None

Sensory: ◯Temperature ◯Pins/Needles ◯Numbness ◯None

Endocrine: ◯Significant Weight Loss/Gain ◯Changes in Appetite ◯Hair loss/Gain ◯None

Urinary: ◯Kidney Stones ◯UTI ◯None