

# Informed Consent to Chiropractic Treatment



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

I \_\_\_\_\_, of \_\_\_\_\_ do  
(Patients Name) (Town of Residence)

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. These manipulations/adjustments may be **performed by any of the chiropractors on staff** at this office. Physical therapy and exercises may also be used.

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 as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

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

**INITIALS** 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 disk, or other abnormality is detected, this office will proceed with extra caution. If a tendon is weak or partially torn, manipulation may cause it to tear the rest of the way.

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

**INITIALS** Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complications from treatment and 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 and function, and reduced muscle spasm. However, I appreciate there is no certainty that 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 persons of the doctor's choosing including other chiropractors that work for this office and certified assistants.

## **INITIALS** Alternative Treatments Available

I understand reasonable alternatives to these procedures may include but are not limited to: rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

INITIALS

**Medications:** Medication can be used to reduce pain or inflammation. I am 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, undesired side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

INITIALS

**Rest/Exercise:** I understand 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 therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

INITIALS

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

INITIALS

**Non-treatment:** I understand the potential risks of refusing or 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 and rehabilitation more difficult and lengthy.

**I have read or have 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

\_\_\_\_\_  
Signature of guardian

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient ID Number

**(Doctor's portion below)**

**Condition of Patient at Time of Consent Process**

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process he/she was:

- Of legal age
- Under the age of 18. The legal guardian of the patient has given consent to the Treatment of this youth.
- Guardian Name: \_\_\_\_\_
- On prescription/OTC medication but unimpaired.
- Resolute in denying the use of alcohol and/or recreational drugs prior to consent.
- Oriented as to time and place.
- Coherent and lucid.
- Able to understand the language used.
- Assisted in understanding by use of an interpreter.

Interpreter's name: \_\_\_\_\_

Assisted in consent process by family members:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Assisted in consent process by staff member.  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I encouraged and answered questions regarding this form with the patient.

PARQ films: \_\_\_\_\_

**Patient had the following questions and was supplied with the following answers:**

Comments: \_\_\_\_\_  
\_\_\_\_\_

I certify that the above accurately described the consent process in this case.

\_\_\_\_\_  
Date

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