# INFORMED CONSENT DOCUMENT

**PATIENT NAME**: _____

**TO THE PATIENT:** Please read this entire document before signing it. It is important that you understand the information contained within this document. Please ask questions before you sign if there is anything that is unclear.

**THE NATURE OF THE CHIROPRACTIC ADJUSTMENT:** The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy, also known as, a chiropractic adjustment. I will use this procedure to treat you. I may use my hands, a mechanical instrument called an Activator, or a drop table to perform the chiropractic adjustment with the intent of influencing your joints. This may cause an audible "pop" or "click," similar to what 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 which will be utilized based upon a history of your condition:

EXAMINATION PROCEDURES WHICH MAY INCLUDE ANY OR ALL OF THE FOLLOWING:

palpation of the spine, extremity joints and associated musculature, vital signs, range of motion testing,

orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing,

other (please explain)

_____
_____

TREATMENT PROCEDURES WHICH MAY INCLUDE ANY OR ALL OF THE FOLLOWING:

spinal manipulative therapy, hot/cold therapy , flexion/distraction , ultrasound, acupuncture, nutritional counseling, home exercises,

other (please explain)

_____
_____

**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: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 the Doctor's attention **it is your responsibility to inform the Doctor.**

**THE PROBABILITY OF THOSE RISKS OCCURRING:**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of the complication occurring. IF there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

**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 choose 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 RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED:**

Remaining untreated may allow the formation of adhesions 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.

**CONSENT OT TREATMENT (MINOR):**

I hereby request and authorize _____ to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above (if applicable). Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

## DO NOT SIGN UNTIL YOU HAVE GONE OVER IT WITH THE DOCTOR AND HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPIRATE BLOCK 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. Grinde or one of her Associates 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 in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

**Dated: _____** **Dated:_____**

**Patient's Name _____** **(Doctor's Name) _____**

**Patient's Signature _____** **(Doctor's Signature) _____**

**_____ Signature of Parent or Guardian if a minor**