Informed Consent For Primary Care

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Analysis / Examination / Treatment As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation and soft tissue massage, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, and radiographic studies.

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain

The availability and nature of other treatment options: Other treatment options for your condition may include: Self-administered, over-the-counter analgesics, rest, medical care, prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization, or surgery.

If you chose 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE 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 the doctor 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.

_____ _____

Patient's Name Parent's Name (If Minor)

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Signature of Patient or Guardian (if a minor) Dated: _____