INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient: _____ **DOB:** _____

Date: _____ **Chart #:** _____

Nature of care. Chiropractic care may include examination, spinal or extremity manipulation (adjustment), manual therapies, and selected adjunctive procedures. The chiropractor will identify the care proposed and explain its intended purpose.

Available services/techniques: ☐ Spinal manipulation ☐ Extremity manipulation ☐ Mobilization/manual therapy ☐ Traction/distraction/decompression ☐ Electrical/ultrasound/diathermy/shockwave ☐ Heat/cold ☐ Instrument-assisted soft-tissue therapy ☐ Exercise ☐ Other: _____

Possible benefits. Possible benefits include temporary reduction of pain or stiffness and improved mobility or function. Results vary, and no outcome is guaranteed.

Risks and side effects. Common effects may include soreness, stiffness, bruising, fatigue, headache, dizziness, nausea, or a temporary increase in pain. Manipulation may cause or worsen muscle, joint, disc, or nerve symptoms and, rarely, fracture, dislocation, neurological injury, or other serious harm. Cervical (neck) manipulation has a rare risk of injury to an artery in the neck, stroke, permanent disability, or death. Traction or decompression may aggravate disc or nerve symptoms. Electrical, ultrasound, diathermy, shockwave, heat, or cold may cause discomfort, skin irritation, burns, dizziness, or interference with implanted devices.

Important disclosures. I will tell the chiropractor before treatment if I may be pregnant; use blood thinners; have osteoporosis, a bleeding disorder, cancer, infection, recent surgery or fracture, vascular disease, significant neurological symptoms, an implanted device, or any condition that may affect treatment safety.

Alternatives. Reasonable alternatives may include no treatment or watchful waiting, self-care, medical evaluation, physical therapy, medication or pain-management care, acupuncture or massage therapy, or surgery when appropriate. If treatment is declined or delayed, symptoms may remain or worsen, although the course cannot be predicted.

Patient-specific concerns or additional risks discussed:

_____

_____

Consent and acknowledgment. I have read this form, or it has been read and explained to me in a language I understand. Before treatment, the chiropractor verbally and in writing explained the nature and purpose of the selected care, its material risks, expected benefits, reasonable alternatives, and any patient-specific concerns. I have had the opportunity to ask questions and received satisfactory answers. I consent to the selected services during this course of care unless I revoke consent. I may decline any procedure or stop treatment at any time. A new discussion and consent will occur if the treatment plan or material risks substantially change. The chiropractor does not guarantee results.

Patient/Representative Signature: _____ **Date:** _____

Relationship (if applicable): _____ **Interpreter/Language:** _____

DC Name: _____ **Interpreter Signature:** _____

DC Signature: _____ **Date:** _____