

**Informed Consent to Chiropractic Care**

**The Chiropractic Adjustment**

The chiropractic adjustment involves the use of hands or a mechanical adjusting device contacting the joints of your body in such a way as to bring motion. This may cause an audible sound such as, “pop” or “click”. You may feel or sense movement in your joints from the adjustment. When receiving a chiropractic adjustment, as with any health care procedure, there are certain risks or complications which may arise.

**The Probability Risks or Complications**

Risks and complications, such as bone fractures, stroke, etc., are rare occurrences with chiropractic care. The doctor conducts tests during your examination that are designed to identify your susceptibility to injury.

**Other Treatments and Risks**

In addition to chiropractic adjustments, the doctor may consider using additional methods of treatment. The treatments listed below may carry certain risks:

* Cyrotherapy (Ice): May cause skin reactions.
* Diathermy (Heat): May cause 1st and 2nd degree burns.
* Low Tech Rehab (Exercise): May cause aggravation of present condition, blood pressure changes, increased heart rate, etc.
* Additional treatments not listed above may be suggested by the doctor and risks explained.

**The Risks Associated with Remaining Untreated**

Remaining untreated may continue the formation of adhesions and reduce mobility. Over time, the formation of adhesions may complicate treatment the longer it is postponed.

**Consent to Treatment**

This office does not diagnose or treat any diseases or conditions other than the vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. The doctor detects and corrects vertebral subluxations using very specific adjustments to the spine. This is the primary practice objective.

I have read the above explanation of chiropractic adjustments and related treatments. All questions have been answered to my satisfaction. By signing below, I state that I understand the risks involved in undergoing treatment(s). I hereby give my consent to Wellness First Chiropractic and Family Wellness to perform the recommended treatment(s).

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Printed first and last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a parent or guardian consenting for the treatment of a minor? 🞏 Yes 🞏 No

If yes, please print minor’s first and last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_