



### ***Informed Consent to Chiropractic Treatment***

**The Nature of Chiropractic Treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of Risks Occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other Treatment Options:** May include over-the-counter analgesics, prescription medications, injections, and surgery.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**No Warranty:** I understand that my doctor at Allison Family Chiropractic, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my doctor will share with me his opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment option with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

WITNESS:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### ***Consent to Treat Minor – For use when applicable***

I hereby authorize Allison Family Chiropractic doctors of chiropractic, to administer chiropractic care, as deemed necessary, to my child.

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Signature (Parent or Guardian)

\_\_\_\_\_  
Date