Informed Consent to Chiropractic Treatment

I hereby request and consent to the treatments offered or recommended to me (or on the patient listed below, for whom I am legally responsible) by my chiropractor and/or other licensed chiropractors who not or in the future work at the clinic, including spinal manipulation and all other joint manipulation, Active Release Technique, corrective exercises, various modalities of physical therapy and diagnostic x-rays. I intend this consent to apply to all my present and future care.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, artery dissection, dislocations, and sprains. Some patients may experience some short-term aggravation of symptoms including soreness, muscle tightness, and ligamentous pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have had the opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures. I understand results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

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Patient or Legal Representative Signature Date

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Witness Signature Date