

Informed Consent Document

Patient Name: _____

To the Patient: 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.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy__palpation__vital signs__ range of motion testing__orthopedic testing__basic neurological testing__ muscle strength testing__postural analysis testing __manual muscle therapy__hot cold therapy__EMS__ acupuncture__ radiographic studies -- Other (please explain)

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization and/or surgery

If you chose to use one of the above notes "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.

Consent to Treatment (Minor)

I hereby request and authorize Schroeder Chiropractic to perform diagnostic test and render chiropractic adjustments and other treatments to my minor son/daughter: _____ authorization also extends to all the other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize healthcare services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Massage Therapy Informed Consent

I understand that massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure will be explained to me. I understand that massage is not a substitute for medical treatment or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy. I will update the massage therapist of any changes in my health, medication or conditions during every massage I receive. Massage appointments require 24hr. notice for any changes. If failure to give notice, prepayment for massage will be required.

Do not sign until you have read and understood 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 Schroeder Chiropractic 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.

Dated:_____

Dated:_____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian (if a minor)