

Patient Name _____

Date of Birth _____

_____/_____/_____
Month Day Year

Please read this form carefully. Ask the doctor about anything you do not understand before you sign.

CHIROPRACTIC CARE

The doctor of chiropractic will use the hands or a mechanical instrument to move the joints of your spine and body. This is called an adjustment. You may hear or feel a click or a pop, and you may feel the joint move. Your care may also include an examination, soft tissue work, stretching, exercise, and supporting therapies such as heat, ice, or electrical stimulation.

POSSIBLE RISKS

As with any health care procedure, complications are possible. Most are minor and pass quickly. They include soreness, stiffness, and a short-term increase in symptoms.

Less common complications include muscle strains, ligament sprains, rib fractures, disc injuries, and nerve irritation. Heat, ice, and electrical therapies can irritate or burn the skin.

Injury to an artery in the neck, which can lead to or contribute to a stroke, has been reported in association with neck adjustments. This is rare.

OTHER TREATMENT OPTIONS

Other options for your condition may include rest, over-the-counter or prescription medication, physical therapy, injections, and surgery. Each has its own risks and benefits, which you can discuss with your medical doctor. You may also choose no treatment. Without treatment, your condition may improve, stay the same, or get worse.

RESULTS

Chiropractic care helps many people. No specific result can be promised or guaranteed.

PATIENT RESPONSIBILITIES

Tell the doctor about your full health history, your medications, and any new symptoms. Tell the doctor if you are pregnant or may be pregnant. Tell the doctor right away if you feel unusual pain or discomfort during or after a treatment.

CONSENT

I have read this form, or it has been read to me. I have had the chance to ask questions, and my questions have been answered. I understand the risks described above. I consent to examination and chiropractic care at Insight Chiropractic. This consent covers my present condition and any future condition for which I seek care at this office. I understand that I may withdraw my consent at any time.

Patient Signature *_____
Date_____
Parent or Legal Guardian Signature (if the patient is a minor)_____
Relationship to Patient