Informed Consent

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common:
- Reactions most commonly reported are local soreness/discomfort, headaches, tiredness, radiating discomfort, dizziness, the vast majority of which resolve within 48 hours

Rare:
- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome
- Compromise of the vertebrobasilar artery. This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor

Please indicate to your doctor if you have a headache or neck pain that is the worst you have ever felt.

I understand that there are beneficial effects associated with these treatment procedures, including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment.

Listed below are summaries of concern with the associated alternative procedures:

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication, the risk of gastrointestinal bleeding, among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care, understand any perceived risk(s), and alternatives to this care.

Patient [or Parent/Guardian] Signature _____

Patient Name [printed] _____

Doctor Signature _____

Video Consent

I grant permission to use quotes from the film, photograph(s), tape(s), or reproduction(s) of me, and/or recording of me, in part or in whole, in its publications, in newspapers, magazines, and other print media, on television, radio and electronic media (internet, social media), and/or in mailings for education and awareness.

Patient [or Parent/Guardian] Signature _____

Patient Name [printed] _____

Doctor Signature _____