



**Informed Consent to Chiropractic Care & Spinal Adjustments**

I understand that the purpose of chiropractic is to restore and maintain the integrity of the spine and nervous system. Vital nerve structures and pathways are housed in and protected by the vertebrae of the spine. Misalignments of these vertebrae interfere with the function of the nerves and are called **subluxations**. Subluxations arise from many sources and can prevent the body from functioning properly. Subluxations are corrected by means of **chiropractic adjustments**, which restore normal nerve function. The goal of chiropractic care is to correct subluxations so that every part of the body has **optimal nerve supply** allowing it to function optimally with maximum natural healing capacity.

I understand that and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks including, but not limited to, muscle strains, sprains, minor fractures, disc injuries, and strokes. While rare, patients may experience short term aggravation of symptoms or muscle/ligament sprains or strains as a result of manual therapy techniques. Although very uncommon, rib fractures have also been reported following certain manual therapy procedures. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, but there is no scientific evidence demonstrating such injuries were caused by spinal adjustments or other chiropractic treatment. While there have been cases of stroke associated with visits to medical doctors and chiropractors, research and scientific evidence does not establish a "cause and effect" relationship between chiropractic treatment and the occurrence of stroke. In any case, the possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

I do not expect the doctor to be able to anticipate and explain all risks and complications, however, I wish to rely on the doctor to exercise judgement during the course of any and all procedures which the doctor feels at the time, based upon the facts then known, are in my best interest. I also understand that as with all health procedures, results are not guaranteed.

I further understand that chiropractic is a hands-on health care discipline that will require the doctor to place his hands on various parts of my body (including but not limited to the hips buttocks), for the purpose of assessment and/or correction of spinal related problems only.

I acknowledge I have read this consent and have discussed or been offered an opportunity to discuss with my doctor, the nature and purpose of chiropractic care and spinal adjustments, alternative treatment options, and recommendations for my condition. I hereby request and consent to the performance of chiropractic **examination procedures, assessment techniques**, the ordering of **diagnostic x-rays** (if necessary), and **chiropractic adjustments or related therapy** as required for my case. I intend for this consent to allow for these procedures to be performed by my **primary doctor** (indicated below), and by **other doctors** (listed below) in the office, if necessary, for scheduling reasons or for continuity of care.

- Dr. Dean MacDonald
- Dr. Mike Weber
- Dr. Lori Jones
- Dr. Tim Lodder

TO BE COMPLETED BY PATIENT / PARENT or GUARDIAN (for patients < 18 years)

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient / Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date