

Nielsen Chiropractic Health Center

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Consent For Treatment

PATIENT NAME (Print) _____

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. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such way as to move your joints. This 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; spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, traction, radiographic studies, nutrition (including injectable) **or any other recommended services.**

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy, and may arise under the best of circumstances. These risks can be minimized if you make certain to give me a full and accurate history, and follow the instructions I give you. 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. We are a team to improve your health, and you need to fully advise of your health conditions, and to comply with our instructions.

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 and X-ray. 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 casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients 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 pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “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 TREAT (MINOR)

I hereby request and authorize Dr. Nielsen to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____ (child’s name). This authorization also extends to all 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 health care 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.

Please mark one of the following options:

- YES, my child may receive chiropractic care without a parent/guardian present.
- NO, my child may not receive chiropractic care without a parent/guardian present. I understand that if my child arrives for an appointment unaccompanied he/she will not be seen.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX 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 Nielsen Chiropractic Health Center and have had my questions answered to my satisfaction. I have fully and accurately disclosed my health history and will comply with instructions that I am given. 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 the treatment.

Dated: _____

Dated: _____

Print Patient’s Name

Doctor’s Name

Patient’s Signature

Signature

Signature of Parent or Guardian (if a minor)