Informed Consent to Chiropractic Care

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Patient Name (print)_____ Date:

Please discuss any questions or concerns with the doctor before signing this consent form.

I hereby request and consent to the performance of chiropractic adjustments as well as other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the office listed above.

I have had an opportunity to discuss with the doctor of chiropractic named above the nature and purpose of chiropractic adjustments and the complimentary procedures that will be used. I understand that results are not guaranteed. Alternative treatments for my condition have been reviewed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. Although complications are very rare the risks include but are not limited to fractures, disc injuries, strokes, dislocations and sprains.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date:

Doctor Signature _____ Date: