# INFORMED CONSENT FOR CARE

PATIENT NAME: _____

**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 a mechanical instrument upon your body in such a way as to move your joints.

**Analysis/Examination/Treatment**

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Vital signs
- Range of motion testing
- Postural analysis testing
- Acupuncture
- Nutrition
- Palpitation
- Neurological testing
- Muscle strength testing
- Orthotics
- Radiological studies
- Health and Wellness

Other _____

**The Material risks inherent in chiropractic adjustment**

- As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. 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.

**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 if necessary.

**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 is postponed.

## CONSENT TO TREATMENT (MINOR)

I hereby request and authorize **McCaffrey Family Health Center** to perform diagnostic test and render chiropractic adjustments and other treatment to my minor son/daughter: _____. 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 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.

By signing below, I state that I have weighed the risks involving in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to be treated.

_____ _____

Patient Signature Patient Name

_____ _____

Date Signature of Parent or Guardian (if a Minor)