Informed Consent for Chiropractic Care

Doctor of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic care, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date:	
Name: (please print)	
DOB:	
Patient Signature:	

Name _____ (M / F) Birth Date (M/D/Y) _____

CURRENT HEALTH COMPLAINT(S)

Please share with us the conditions or symptoms that have brought you into our office. If you have any questions about how to answer this section, please let us know. If this is for a wellness or spine checkup, please mark here [ ].

	1	2	3
Health Issue:			
Severity (1-10):			
How Long:			

HEALTH HISTORY FORM

Please check if you suffer from, previously suffered from, or are concerned you suffer from any of the following;

Musculoskeletal
Headaches ____
Arthritis ____
Neck pain ____
Back pain ____
Low back pain ____
Sciatica ____
Shoulder pain ____
Elbow/arm/wrist pain ____
Hip pain ____
Knee pain ____
Shin/ankle pain ____
Osteoporosis ____
Other _____

Digestive
Constipation ____
Diarrhea ____
Incontinence ____
Other _____

Cardiac
Heart attack ____
High/low blood pressure ____
Stroke ____
High cholesterol ____
Aneurysm ____
Angina ____
Other _____

Respiratory
Pneumonia ____
Asthma ____
Pleurisy ____
Sinus conditions ____
Other _____

Other
Fatigue ____
Cancer ____
Diabetes ____
Erectile dysfunction ____
Skin conditions ____
Chronic flu/colds ____
Epilepsy ____
Visual challenges
Allergies ____
STI's ____
Hearing problems ____
Psoriasis ____
Hepatitis ____
Other _____

Women's Health
Ovarian cysts ____
PMS symptoms ____
Painful menstruation ____
Irregular menstruation ____
Other _____