INFORMED CONSENT TO TREATMENT
For Minor

The undersigned is the parent or legal guardian of the minor _____ who explicitly and specifically consents to the treatment of said minor.

Doctors of chiropractic, chiropractic assistants and massage therapists who use manual therapy techniques such as spinal adjustments, kinesio-taping/strapping, cryotherapy, neuromuscular reeducation, massage, should advise patients that there are or may be risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures, muscle strains and/or ligament sprains **following spinal manipulation.**

b) There have been reported cases of injury to a vertebral artery following **cervical spinal adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) **Kinesio-Taping/Strapping, heat and cyrotherapy (ice) :** skin reactions or burns

Chiropractic treatments, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches being and other similar symptoms. The risk for 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 doctor and his staff the nature and purpose of the treatments in general and my treatment in particular (including spinal adjustments) as well as the contents of this Consent. I consent to the treatment offered or recommended to the minor child including spinal adjustments. I intend this consent to apply to all his/her present and future care.

TO BE COMPLETED BY PATIENT'S PARENT OR LEGAL GUARDIAN:

Date signed:

Parent or Legal Guardian Signature:

Parent or Legal Guardian Name_____
Patient Name:
(Please Print)

Witness Signature:

Witness Name:
(Please Print)

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

_____
translated by

_____
date