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INFORMED CONSENT -- CHIROPRACTIC CARE

This document is intended to inform you of risks and cautions associated with chiropractic care. Please read carefully before signing, acknowledging you are informed.

GENERAL

I, the below-signed patient/individual, have read this document in entirety and understand the potential benefits and risks of the care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the care which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy or *spinal adjusting*. We will use that procedure, known as an *adjustment* to treat you. We may use *my hands* or a *mechanical instrument* upon your body in such a way as to remove the muscular or boney restriction and *free up your body to move properly*.

ANALYSIS, EXAMINATION, AND TREATMENT

As a part of the analysis, examination, and treatment, you are consenting to the following procedure: vital signs, spinal adjustment, palpation, range of motion testing, orthopedic testing, any necessary neurological testing, muscle strength testing, postural analysis testing, and any necessary radiographic studies.

POSSIBLE RISKS OF THE CARE

I understand that there are certain complications, as with any healthcare procedure, that may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. If you have augmented breasts, glutes or calves, the thrust of the adjustment could rupture the internal structure. 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. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

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ALTERNATIVES
I understand that other treatment options for my condition may include: self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; surgery; pain management care; acupuncture; craniosacral therapy; and massage therapy.

CONTRAINDICATIONS
I understand that you will not give me an adjustment, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the care does not include such procedures, I have been informed of contraindications. If I develop a concern about the safety of my care, I will clearly express my concern with you. Pregnancy is not a contraindication for care (in our opinion it is the best time to get adjusted). Although, we strive to practice within boundaries that you or your birth professionals find appropriate. If you have concerns related to chiropractic care during pregnancy, or especially infant care, please express these plainly to your provider to allow your expectations to be met comfortably.

PATIENT'S CONSENT
I am informed of general information, associated risks, and contraindications related to chiropractic care that I am seeking. I will discuss and review recommendations with you. I will ask questions when I don't understand the provided information. I will object when I disagree with the recommendations provided. I will give you adequate notice of apprehensions or disapproval to allow you to make changes in your approach or to stop treatment. I understand that if there are better forms of care suited for my needs, or especially if further study is needed before beginning chiropractic care, you will notify me and allow me to make an educated decision.

I voluntarily and knowingly elect to receive the recommended care.

Dated: _____ Dated: _____

_____ Dr. Jessica Solis/Dr. Ross Solis_____
PATIENT'S NAME **DOCTOR'S NAME**

_____ _____
PATIENT'S SIGNATURE **DOCTOR'S SIGNATURE**

_____
SIGNATURE OF PARENT OR GUARDIAN (if a minor)