

## **Informed Consent**

Patient Name: \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### **The Nature of the Chiropractic Adjustment**

The primary treatment I use as a Doctor 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. That may cause an audible pop or click, as you may have experienced when you crack your knuckles. You may feel a sense of movement.

### **Analysis/Examination/Treatment:**

*(Please note that all of the following may take place during the course of treatment. Check with Dr. Miller if you should have any questions regarding any of these procedures prior to initialing.)*

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

spinal manipulative therapy	radiographic studies	vital signs
range of motion testing	orthopedic testing	palpation
muscle strength testing	postural analysis	
basic neurological testing	hot/cold therapy	

***Patient: please initial that you are consenting to the procedures listed above:\_\_\_\_\_***

### **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, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of 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 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 my attention, it is your responsibility to inform me.

### **The Probability of Those Risks Occurring:**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The Availability and Nature of Other Treatment Options:**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization.
- Surgery.

If you chose to use one of the above noted other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**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 it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. David Miller and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient s Name

*David S. Miller, D.C*  
\_\_\_\_\_  
Doctor s Name

\_\_\_\_\_  
Patient s Signature

\_\_\_\_\_  
Doctor s Signature

\_\_\_\_\_  
Signature of Parent or Guardian If A Minor