Informed Consent to Chiropractic Treatment

Doctors of Chiropractic are required to advise patients that there are risks associated with treatment, as with any health care procedures, there are certain complications which may arise.

1.) While rare; some patients may experience short term aggravation of symptoms including soreness, muscle tightness, and ligamentous pain.
2.) There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million will experience stroke. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) There are also reported cases of strain/sprain injuries of ligament and muscle, rib fractures in osteoporotic patients, aggravation of low-back disc herniations, fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains & separations. Again this is rare and the techniques employed by Dr. Larsen reduce that risk even more.

Chiropractic treatment, including manipulation, has been the subject of government reports and multi-disciplinary studies, and has been demonstrated to be safe and effective care option for the treatment of back and neck pain as well as headaches. Other conditions involving radiating pain, numbness, muscle spasm, loss of mobility and other symptoms have also shown improvement.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the *facts* then known, and are in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below. I intend this consent to apply to all my present and future chiropractic care.

I have had an opportunity to discuss with the doctor named below and/or with the office personnel the nature, purpose, and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

____________________ Patient Signature	____________________ Patient Name (Please Print)
____________________ Witness Signature	____________________ Date

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