INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited to; a comprehensive exam, diagnostic x rays, various modes of physical therapy as well as nutritional and exercise recommendations by the licensed Doctors of Chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: bruising, soft tissue swelling, fractures, dislocations, stroke, muscle strain, costovertebral sprains and separations. We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the Doctor(s) to anticipate all risks and complications during the course of my treatment, based on the facts known about my medical history.

I have had an opportunity to discuss with the Doctor the nature, purpose and risk of Chiropractic adjustments and other recommended procedures and have had all my questions answered to my satisfaction. I understand that the results are not guaranteed.

Massage:
Draping will be used by the therapist as required to expose only the areas of my body that require treatment and/or to my comfort level. I hereby request and consent to the performance of massage therapy by the licensed massage therapist at this office.

Acupuncture:
I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice. I understand that methods of treatment may include, but are not limited to, Chinese herbal medicine and nutritional counseling. The herbs may have an unpleasant smell or taste. I have been informed that acupuncture is generally safe, but it may have some side effects including; bruising, numbness, tingling near the needling sites that may last a few days, dizziness and/or fainting. I agree to the risks and benefits of acupuncture by the licensed Acupuncturist at this office.

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 risk(s) involved in undergoing treatment and I have decided that is in my best interest to undergo chiropractic, massage and/or acupuncture treatment. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment, and any and all health care providers who provide treatment at, or are associated with this office.

_____	_____	
Guardian/Patient's Name (Printed)	**Guardian/Patient's Name (Signature)**	
_____	____/____/____	_____
(if minor) Patient's Name (Printed)	**DOB**	**Date**

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