



Informed Consent to Render Treatment For Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, and soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities, or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have ever felt.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help improve my condition. The patient examination process includes important tests that require movement, exertion, balance control and may result in worsening of symptoms, muscle spasm, and falling. I accept these risks and agree that I will provide correct answers to information and will notify Healing Touch Chiropractic if there has been any change in any of my answers and information.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks.
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.
- Potential risks if refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.

Neck and back pain generally improve in time, however, reoccurrence is common. Remaining active and positive improve your chances of recovery.

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Please answer the following questions to help us determine possible risk factors:

GENERAL	YES	DOCTOR'S COMMENTS
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	<input type="checkbox"/>	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	<input type="checkbox"/>	
Do you take corticosteroids (e.g. prednisone)?	<input type="checkbox"/>	
Have you been diagnosed with a compression fracture(s) of the spine?	<input type="checkbox"/>	
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	
Do you have any metal implants?	<input type="checkbox"/>	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	<input type="checkbox"/>	
If yes, about how much do you take daily? _____		
Do you take warfarin (Coumadin), heparin, or Other similar "blood thinners"?	<input type="checkbox"/>	
Ever been diagnosed with any of the following disorders or diseases:		
• Rheumatoid arthritis	<input type="checkbox"/>	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	<input type="checkbox"/>	
• Giant cell arteritis (temporal arteritis)	<input type="checkbox"/>	
• Osteogenesis imperfecta	<input type="checkbox"/>	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	<input type="checkbox"/>	
• Medial cystic necrosis (cystic mucoid degeneration)	<input type="checkbox"/>	
• Bechet's disease	<input type="checkbox"/>	
• Fibromuscular dysplasia	<input type="checkbox"/>	
• Have you ever become dizzy or lost consciousness when turning your head?	<input type="checkbox"/>	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	<input type="checkbox"/>	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	<input type="checkbox"/>	
Have you been diagnosed with spondyliolithesis?	<input type="checkbox"/>	
Have you ever had any of the following problems?		
• Sudden weakness in the arms or legs?	<input type="checkbox"/>	
• Numbness in the genital area?	<input type="checkbox"/>	
• Recent inability to urinate or lack of control when urinating?	<input type="checkbox"/>	

I have read the previous information regarding the risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient (or parent/guardian) Signature _____

Date: _____