INFORMED CONSENT TO CHIROPRACTIC TREATMENT

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health. One disturbance of the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. As a chiropractic facility we have one main goal; to detect and correct/reduce the vertebral subluxation complex.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click". You may also feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

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

___spinal manipulative therapy ___palpation ___vital signs ___range of motion testing ___ultrasound

___orthopedic testing ___basic neurological testing ___muscle strength testing ___electrical stimulation

___postural analysis ___hot/cold therapy ___therapeutic exercise ___traction ___radiographic studies

___trigger point compression ___all of the above

Patient should initial each procedure they are consenting to OR initial "all of the above".

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The complications include but are not limited to: fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strain/separation, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serios complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor 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 the doctor's attention, it is your responsibility to inform the doctor.

THE PROBABILITY OF THOSE RISKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone. We check for weakness by taking your health history, during examination, and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. Research and scientific evidence do not establish a cause-and-effect relationship between chiropractic treatment and occurrence of stroke, rather, recent studies indicate that patients may be consulting medical doctors or chiropractors when they are in the initial stages of a stroke. In essence, there is a stroke already in progress. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition 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 choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of these options and you may wish to discuss these with your primary care 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 costly and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE MAKE SURE THAT YOU HAVE INITIALLED ALL THE APPROPRIATE SPACES ON THE OTHER SIDE, THEN SIGN BELOW.

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 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. I UNDERSTAND THAT THIS CONSENT IS VALID FOR 3 YEARS. I also understand that I have the right to revoke this consent and make changes upon my request. I understand that if I revoke this CONSENT, any time, Leavengood Chiropractic has the right to refuse treatment to me.

PRINT PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

DATE: _____

CONSENT TO TREAT MINOR

I hereby authorize Leavengood Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable), Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize care should be revoke or modified in any way, I will notify this office immediately.

SIGNATURE OF PARENT OR GUARDIAN OF MINOR: _____

DATE: _____