LAKESIDE CHIROPRACTIC CLINIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilisation, are required to inform patients that there are or may be some risks associated with such treatment. In particular: -

a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.
b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilisation. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and /or mobilisation, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilisation to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). **T**his consent applies to all my present and future treatments at this clinic.

24 Hour Cancellation policy: If you miss your appointment or cancel within 24hrs, you will be charged a fee for that appointment. By giving last minutes notice, you prevent someone else booking into that time slot. Thank you for your understanding.

Dated this _____ day of _____, 20_____

_____ Name: _____
Patient signature (Please print name of the patient)

_____ Name: _____
Signature of guardian (when applicable) (Please print name of guardian)

_____ Name: _____
Signature of Witness/Translator (Please print name of witness/translator)