



4433 N Oakland Ave.  
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## **INFORMED CONSENT**

PATIENT NAME: \_\_\_\_\_

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

**\* The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “rack” your knuckles. You may feel a sense or some movement.

**\* The material risks inherent in chiropractic adjustment.**

Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

**\* The risks and dangers of remaining untreated.**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and have had my questions answered to my satisfaction. 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 treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATE \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Parent or Guardian for a minor

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Witness Signature