Function.*allied* Health

CHIROPRACTIC CONSENT FORM

Chiropractic Care, when performed by a qualified Chiropractor has been found to be both an effective and safe form of care for many health conditions. There are, however, risks associated with any treatment no matter how small, that you need to be informed of. Because of this we ask that you read the following carefully.

- ☐ I understand there are very minimal risks resulting from treatment, such as but not limited to: muscle and joint soreness, sprain, muscle strain, disc injury, nerve irritation or damage.
- ☐ I understand in extremely rare cases, some treatments to the neck may result in injury to blood vessels and give rise to stroke or stroke like symptoms.
- ☐ I understand that results are not guarenteed and that consent can be withdrawn at any time.

For X-ray purposes:

Are you pregnant or is there a chance that you are pregnant?

☐ Yes How many weeks? _____
☐ No

- ☐ I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from any registered Chiropractors practicing at Ferny Chiropractic Clinic.
- ☐ I have read, or have had read to me the above content and I have also had an opportunity to ask questions about this content.

Patient Name (PRINTED): _____

Patient Signature (or Parent/Guardian): _____

Date: _____

Practitioner Name (PRINTED): _____

Practitioner Signature: _____

Date: _____

Please return this form to reception.