



## **Informed Consent for Chiropractic Care**

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To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in the document. Please ask questions before you sign if there is anything that is unclear.

### **The nature of the chiropractic adjustment**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use some type of spinal manipulative therapy and adjunctive therapies to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your bones. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement. As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, range of motion testing, orthopedic and neurological testing, muscle strength testing, postural analysis, hot/cold therapy, massage, and/or radiographic studies.

### **The material risks inherent in chiropractic adjustment**

Chiropractic examination and therapy are considered very safe and effective methods of care. Occasionally, however, complications can arise. Any procedure intended to help may have complications. While the chances of experiencing are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation bruising, fractures, disc injury, dizziness, worsening of symptoms, strokes, dislocations, nerve damage, strains and sprains, and burns. Some types of adjustments to the neck have been associated with injury to the neck arteries, leading to or contributing to serious injury, including stroke. I 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 my attention, it is your responsibility to inform me.

### **The probability of those risks occurring**

Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur in between one in one million and one in five million cervical adjustments. Soreness after a treatment, especially after the first one, is not uncommon. The other complications are also generally described as rare.

### **Treatment results**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

### **The availability and nature of other treatment options**

Other treatment options are available for your condition and may include: Self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization, or surgery. If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

### **Non-treatment**

I understand the potential risk of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely and I hereby affix my signature to authorize treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_