Chiropractic Treatment Consent

Informed consent. The chiropractor fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

CHIROPRACTOR NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

AREA TREATED

SESSIONS PLANNED

Treatment involves quick, controlled movements of joints, which may make a popping sound, along with soft-tissue work and stretching.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Soreness or stiffness for a day or two
- Headache or dizziness
- Rib fracture in people with weak bones (rare)
- Very rarely after neck manipulation, injury to an artery causing stroke

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Physiotherapy and exercise
- Medicines
- Treatment without neck manipulation

Your health

Do you have osteoporosis?

○ No ○ Yes

Have you had a stroke, blood-vessel disease or recent neck injury?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

☐ I do NOT want neck manipulation.

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The chiropractor has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Chiropractor

SIGNATURE

PRINTED NAME

DATE