Informed Consent for Chiropractic Care

Consent form explaining the nature, risks, and benefits of chiropractic treatment including spinal manipulation

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Nature of Chiropractic Treatment

Chiropractic Care Overview:

Chiropractic care involves the diagnosis and treatment of musculoskeletal conditions, primarily through manual adjustment and manipulation of the spine and other joints. Your treatment plan may include:

- Spinal adjustments (manual or instrument-assisted)
- Joint mobilization and soft tissue therapy
- Therapeutic exercises and stretches
- Electrical stimulation, ultrasound, or cold laser therapy
- Lifestyle and ergonomic advice

The goal of chiropractic care is to restore proper alignment and function, reduce pain, and improve your overall quality of life.

Risks & Benefits

Potential Benefits:
- Pain relief and improved mobility
- Reduced inflammation
- Improved posture and spinal alignment
- Enhanced nervous system function
- Reduced dependence on pain medication

Potential Risks of Spinal Manipulation:

While chiropractic adjustments are generally very safe, some risks include:

- Temporary soreness or discomfort in the treated area (most common)
- Headache or fatigue following treatment
- Aggravation of existing condition (temporary)
- Muscle spasm or strain
- Rib fracture (rare, more likely with osteoporosis)
- Disc herniation or worsening of existing disc condition (rare)
- Stroke or vertebral artery dissection following cervical (neck) manipulation — this is extremely rare (estimated at 1 in 1-5 million adjustments) but can be serious

Alternatives to Chiropractic Care:
- Over-the-counter or prescription medications
- Physical therapy
- Massage therapy
- Surgical intervention
- No treatment (with potential for condition to worsen)

I acknowledge that I have been informed of the potential risks and benefits of chiropractic treatment, including the rare but serious risk of stroke associated with cervical manipulation.

I understand the risks and benefits described above: _____

I understand the additional risks specifically associated with cervical spine manipulation and consent to receive this treatment if my chiropractor determines it is appropriate for my condition.

I specifically consent to cervical (neck) adjustments: _____

Patient Rights

Your Rights as a Patient:

1. You have the right to ask questions about any proposed treatment at any time.
2. You have the right to refuse or discontinue any treatment at any time.
3. You have the right to a second opinion.
4. You have the right to know the qualifications of your treating provider.
5. You have the right to request modification of your treatment plan.
6. You have the right to privacy and confidentiality of your health information.

I confirm that I understand my rights as a patient, including the right to refuse or discontinue treatment at any time.

I acknowledge my rights as described above: _____

Consent & Signature

By signing below, I confirm that I have read this informed consent form in its entirety. I understand the nature of chiropractic care, the potential risks and benefits, and the alternatives available. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily consent to receive chiropractic care as recommended by my chiropractor.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

Date

Print name

Date *

MM / DD / YYYY