

Wagner Integrative Therapies  
875 N. Easton Rd., Ste 5B  
Doylestown, Pa 18902

## Informed Consent Document for CHIROPRACTIC CARE

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

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

### The nature of the chiropractic adjustment.

One of the primary treatments used by Doctor of Chiropractic is spinal manipulative therapy. I may use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

### Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you may be consenting to the following procedures: **Y for YES, N for NO**

\_\_\_\_\_ spinal manipulative therapy    \_\_\_\_\_ palpation    \_\_\_\_\_ vital signs  
\_\_\_\_\_ range of motion testing    \_\_\_\_\_ orthopedic testing    \_\_\_\_\_ basic neurological testing  
\_\_\_\_\_ muscle strength testing    \_\_\_\_\_ postural analysis testing  
\_\_\_\_\_ radiographic studies review

*Patient, please initial ONLY procedure(s) you are consenting to.*

### The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor. \_\_\_\_\_

### The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and review of X-ray, MR, CT or other studies which you have made available to the doctor. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke. \_\_\_\_\_

Other treatment options for your condition may include:

\_\_\_\_\_ spinal decompression therapy \_\_\_\_\_ ultrasound  
\_\_\_\_\_ class 4 laser therapy \_\_\_\_\_ extracorporeal pulse activation therapy (EPAT)

The availability and nature of other treatment options.

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose 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.

The risks and dangers of remaining untreated.

Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**\*\*CONSENT TO TREATMENT OF A MINOR CHILD**

I hereby request and authorize. *J. Adam Wagner, D.C.* to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:

\_\_\_\_\_. This authorization also extends to all other doctors and office staff members and is intended to include radiographic review when possible, at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *J. Adam Wagner, D.C.* 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 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.

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Patient's Name

Patient's Signature

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Signature of Parent or Guardian (if patient is a minor)

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Witnessed Date

Witness Signature