

# **Erickson Clinic of Chiropractic**

## **Informed Consent to Chiropractic Treatment**

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.**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will 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. 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.

### **Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- ultrasound
- radiographic studies
- vital signs
- other \_\_\_\_\_
- palpation
- orthopedic testing
- postural analysis
- hot/cold therapy
- basic neurological testing
- electrical muscle stimulation

### **The material 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. 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.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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

Other treatment options for your condition 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
- 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 attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce 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.

# **Erickson Clinic of Chiropractic**

## **Informed Consent to Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments, and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally respon-

sible: \_\_\_\_\_)  
by Dr. Rick Erickson and/or anyone working in this office authorized by Dr. Erickson.

I further understand that such chiropractic services may be performed by Dr. Rick Erickson and/or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Erickson and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA) dislocations, costovertebral strains/sprains and burns. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the doctor feels are in my best interests at the time, based upon the facts then known.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

**To be completed by the patient:**

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Representative

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Verbal review/discussion with patient and patient verbalizes consent

\_\_\_\_\_  
Staff doctor