Patient Name: _____

Consent to Examine and Treat

The undersigned consents to any examination including, but not limited to, physical, orthopedic and neurological evaluation, radiographic (x-ray) examination, visual inspection, palpation and exercise stress test.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, electrical therapy, traction, muscle stretching, heat/ice application, nutritional supplementation, acupuncture, dry needling and rehabilitative exercise.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help also may do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include and are not limited to: pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heat attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures. I am also acknowledging that I have received a copy of this form.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

_____ There is a possibility that I may be pregnant at this time. _____ Yes. I am definitely pregnant.

_____ No. I am definitely not pregnant at this time. **Date of last menstrual period:** _____

_____

Patient's Signature Date