CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, with all health care procedures there is a health risk which you are now required by law to be informed about. This form is not meant to scare or alarm you, it is simply an effort by this clinic to make you better informed and is done to satisfy legal requirements.

In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.).
For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

As part of our commitment to gentle, specific, controlled and effective Chiropractic care and your chiropractor's belief in the body's natural ability to heal itself, your chiropractor has found that in most cases it is not necessary to use manual neck manipulation. There is a very small risk involved in damage occurring to the nervous system when manual neck manipulations are conducted.

I support the fact that the body needs only facilitation and not force in order to heal.

Please read the following carefully:

1. Aspire Health and Function prioritises safe treating conditions for both the patient and the practitioner. To assist with this, all assessment and treating areas inside our clinic have audio and video technology installed. By signing this document, I acknowledge, consent to and accept that this footage will be stored in a password protected hard drive for the sole use of monitoring patient and practitioner safety and will not be used for any other purpose.

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.
   ……
   (Insert details)
   ……

3. I acknowledge that I have been informed of the rare risks associated with my proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition.

4. I acknowledge that I am aware of and understand the potential risks from manual manipulation. I appreciate that results are not guaranteed.

5. I do not expect the chiropractor to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of a physical examination including head, neck, shoulders, arms, front and back of the thoracic area, lower back, abdomen (stomach), gluteal area, legs, including thighs and feet by my treating chiropractor in this clinic.

7. I hereby acknowledge my consent to the performance of a physical examination and the proposed chiropractic care by my treating chiropractor at this clinic. I understand that I can withdraw consent at any time.

_____ _____

Client's Name (printed) Client's signature
(*Parent or guardian if client is under 18 yrs)*

Date _____

Thank you for taking the time to complete these forms
This information will be recorded in your Personal File as Private and Confidential.

……Office Use ……

To be completed by DC or CA
Witness to client's signature _____ *Dated*_____

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