INFORMED CONSENT

After reviewing your health history, the doctor will examine you and may require other diagnostic tests i.e. xrays, MRI or lab tests to make an accurate diagnosis and treatment plan. The doctor will select a treatment plan, which best suits your needs. You will be informed of all alternative treatment options. Occasionally the plan may have to be altered during treatment due to unexpected changes. We request that you voice all questions and concerns to the doctor so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from chiropractic treatment. They are as follows: muscle soreness, irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

If there is anything you do not understand, please discuss it with the doctor before signing the statement below.

I certify the information provided for the health history is true and factual to the to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which was supplied in the statement above. Any additional information, which may occur, will be supplied to you. I hereby consent to chiropractic treatment.

_____ _____

(Patient's Signature) (Date)

The patient is unable to consent because_____ (i.e. underage, etc.) I, therefore, consent for the patient.

_____ _____

(Signature) (Date)

Relationship to patient: _____