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Patient Name_____ Date_____

Treatment Modalities (circle all that apply)

Chiropractic Adjustment/Manipulation

Cryotherapy/Ice Pack Electric Muscle Stimulation

Exercise/Stretching Hot Moist Pack (HMP) Ultrasound

Instrument Assisted Connective Tissue (IACTM) Manual/Manipulation

Other: _____

I have received information from my doctor about my condition and proposed chiropractic treatment program, including the anticipated benefits, the reasonably foreseeable risks and side effects of the treatment, and alternatives to the proposed treatment, including no treatment.

I understand that, as in all health care, there are some risks to chiropractic treatment. The risks include but are not limited to bruising, soreness, worsening of symptoms, muscle strains, sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which th doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have had the opportunity to ask questions about my condition ad the recommended care, and my doctor has answered all questions to my satisfaction. I understand that I may ask further questions at any time.

_____ _____
Patient/Guardian Signature Date

_____ _____
Doctor's Signature Date