Informed Consent For Treatment:

PATIENT NAME:
To the patient: Please read this 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:
One of the main modalities used as a Chiropractor is manipulative therapy mainly to the spine. This will be done by hands or with a mechanical instrument upon the body in such a way as to move the joints of the spine and upper and lower extremities. This may cause an audible “pop” or “click”, just the same as when one “cracks” their knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As part of the analysis, examination, treatment you are also consenting to the following procedures:

- CranioSacral Therapy
- Palpation
- Neurological Testing
- Range of motion Testing
- Vital signs
- Muscle strength Testing
- Spinal Manipulative Therapy
- Acupuncture
- Postural Analysis
- Muscle testing
- Palpation
- Orthopedic Testing
- Joint Manipulation
- Other

The inherent risks in chiropractic adjustment:
As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation. These complications include but are not limited to fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations. 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. 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. Also some patients might feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history 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 inherent risks in CranioSacral therapy:
There are very few risks involved in CranioSacral therapy as it is a light touch gentle treatment
that works with your body’s own inherent healing mechanisms, its aim being the improvement in
function of a physiologic system. The risks are when there is a condition of increasing the
intracranial pressure is contraindicated and those times are acute conditions of intracranial
hemorrhage, an aneurysm, recent skull fracture and herniation of the brain stem.

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. At times hospitalizations or surgery might be needed.
If you choose one of the above “other treatment” options, you should be aware that there are risks
and benefits of such options which I encourage you to discuss these with your primary medical
physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLease check the appropriate block and sign below.
I have read (    ) or I have had read to me (    ) the above explanation of the chiropractic
adjustment and related treatment. I have discussed it with Dr. Lisa Upledger and have had my
questions answered to my satisfaction. By signing below I state that I have weighed the risks
involved in undergoing treatment and have decided that it is in my best interest to under
go the treatment recommended. Having been informed of the risks I hereby give my consent to
that treatment.

DATED: ______________________                              DATED: ______________________

_____________________________                               ______________________________
Patient’s name                                                                  Doctor’s name

___________________________________                                  ______________________________________
Signature                                                                           Signature

______________________________
Signature for minor parent or guardian