Dr. Kristen Steely, D.C.

<u>Informed Consent for Chiropractic Support/Management Care</u>

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic and other healthcare practitioners. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

b) There are reported cases of stroke associated with visits to **medical doctors, osteopaths, physical therapists and doctors of chiropractic.** **<u>Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of stroke.</u>** Recent studies suggest that patients may be consulting medical doctors and chiropractors <u>when they are in the early stages of a stroke.</u> **In essence, there is a stroke already in progress.** However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with **upper cervical adjustment is extremely remote.**

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although **no** scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electoral therapy offered by some doctors of chiropractic.

e) <u>Care Results:</u> I also understand that there are beneficial effects associated with these procedures including decreased pain, improved mobility and function, reduced muscle spasm and restored activities of daily living. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge **that no guarantee** has been made to me regarding the outcome of these procedures. I appreciate there is no certainty that I will achieve these benefits.

f) <u>Nutritional Therapy/Supplement(s):</u> Is intended to reinforce systemic and metabolic health and **<u>is not intended</u>** to diagnose, treat, cure or prevent any disease.

g) <u>Alternative Treatments Available:</u> Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

<u>Medications:</u> Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate o short-term relief, undesirable side-effect, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

<u>Rest/Exercise</u>: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

<u>Surgery:</u> Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

<u>Non-treatment:</u> I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I acknowledge I have read this consent. I have discussed or have been offered the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic care in general, (included spinal adjustment), the care options and recommendations to support/manage my condition, and the contents of this Consent. I consent to the chiropractic care recommended to me by my Doctor of Chiropractic including any recommended spinal adjustments, nutritional therapies and/or functional therapies. I intend this consent to apply to all my present and future chiropractic care. I have made my decision voluntarily and freely.

Dated this _______ day of ___________________, 20 ______. **Time: ___________**

x____________________________________ **x__________________________________**

Patient's Signature/Legal Guardian **Witness Signature**

x ______________________________________
Print Patient's Name

x ______________________________________
Print Witness's Name