

# Consent Form

## CONSENT TO CHIROPRACTIC EXAMINATION

I hereby consent to the performance of a chiropractic assessment by the chiropractor, including: physical, neurological and orthopaedic tests. This may include reflexes, range of movement and the taking of a series of postural photos and x-rays.

Possible complications could be exacerbation (irritation) of existing symptoms or muscle strain or stiffness after the assessment.

\_\_\_\_\_  
Patients Signature  
(Parent or Guardian to sign if patient is under 17 years)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Witness Name

\_\_\_\_\_  
Today's Date

## CONSENT TO CHIROPRACTIC X-RAY

I consent to the chiropractor at Coast Chiropractic Caboolture taking x-rays.

I understand that the purpose of this is to:

- Reveal pathologies and degeneration
- Show a history of my spinal stresses
- Visualise the location of spinal problems
- Confirm other examination findings
- Record structural and functional progress

I confirm that I am not pregnant.

\_\_\_\_\_  
Patients Signature  
(Parent or Guardian to sign if patient is under 17 years)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Witness Name

\_\_\_\_\_  
Today's Date

Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, changes to the law now require all practitioners to warn patients of risks.

Please read the following carefully;

1. I acknowledge that I have discussed with the chiropractor 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, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition.

Extremely rare risk of stroke. Some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx 1 in 5.85 million. Neck manipulation. Haldeman. et al. Spine vol 24-81999). Whilst this has never occurred in this practice, we are still required to warn.

Other very slight risks include strain/injury to ligament or disc in the neck (less than 1 in 139,00), or the lower back (1 in 62,000). (Dvorak study in Principals and Practice of Chiropractic, Haldeman. 2 nd Ed).

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (Risk Assessment of Cervical Manipulation. JMPT, 1995. Manga Report Ontario Ministry of Health 1993).

2. I have had the opportunity to discuss the proposed care with the chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care to proceed.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed and I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
4. I hereby acknowledge my consent to the performance of the proposed chiropractic care, by any chiropractor at Coast Chiropractic Caboolture and understand that I can withdraw my consent at any time.
5. I give permission to use the records for study, research purposes and professional care presentations.

\_\_\_\_\_  
Patients Signature  
(Parent or Guardian to sign if patient is under 17 years)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Witness Name

\_\_\_\_\_  
Today's Date