

INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ AND INITIAL ON EACH BLANK LINE

_____ I acknowledge that during the course of my care, I or the person named below for whom I am legally responsible, may receive chiropractic adjustments and other procedures including various modes of physiotherapy and diagnostic x-rays. These services and treatments will be provided by licensed Chiropractors and or Chiropractic interns under the supervision of licensed Chiropractors provided by the Southern California University of Health Sciences (SCUHS).

_____ I understand that as in the practice of medicine, in the practice of other clinical therapies, there are some risks to treatment. If I receive chiropractic treatment, the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fracture, dislocations, stroke (Cervical Spine Related), sprains/strains, burns and aggravation of disc injuries

_____ I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him/her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known is in my best interest.

_____ I have no further questions at this time for the doctor

I have read, or have had read to me, the above consent. By signing below, I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (**PLEASE PRINT**)

Today's Date

Signature of Patient (or guardian if patient is minor)

Today's Date

Signature of Witness

Today's Date