

**Island Health & Chiropractic ~ 9431 Coppertop Loop NE STE 204 ~ Bainbridge Island, WA 98110
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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS

Chiropractic treatment consists of manipulations of joints and soft tissues, using the hand and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Some patients will feel some stiffness and soreness following the first few days of treatment; these are normal and not a cause for concern. There are different techniques used in Chiropractic spinal manipulations. There are also alternatives to Chiropractic care, including but not limited to: Physical Therapy, Massage therapy, Osteopathic manipulations, and Medical care. There are also material risks inherent in the above listed alternatives, which should be discussed between you and the specialty care provider. You also have the option of not seeking any care. The risk of remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain risks, which may arise during the exam and treatment. Those complications include: strokes or stroke-like conditions, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, pathological fracture, cervical disc protrusions, cervical dislocations, costovertebral strains, rib fractures, costochondral separations, compression of the cauda equina. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The risks of massage are bruising, local tenderness, and the release of toxins in the body. There are also risks in taking nutritional supplements, please contact your Primary Care Physician/health care practitioner before using any nutritional products, including those dispensed in this office.

I have read or have had read to me the above explanation of the nature and purpose of chiropractic adjustments, other alternatives/procedures for care, massage, and possible risks. I have also had the opportunity to ask questions about its content 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 myself decided that it is in my best interest to undergo the treatment recommended, and listed below. Having been informed of the risks, **I hereby request and consent to the performance of** chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays-if warranted, massage, and the use of natural substances such as vitamins, minerals, or other natural substances on me or on the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or servicing as backup for the doctor of chiropractic named below and by the Licensed Massage Therapist listed below, including those working at the clinic or office listed below or any other office or clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient: *If patient is a **MINOR**, this section to be complete by patient's legal guardian, legally responsible adult.*

PRINT Patient's Name

PRINT Patient's Name

Signature of Patient

PRINT Name of Patient's Guardian

Date

Signature of Patient's Guardian

Date

To be completed by
Island Health & Chiropractic

Provider's Signature

Date