

INFORMED CONSENT

The material risks inherent with Spinal Decompression: Certain complications may arise such as muscle spasm or increased pain. The spasm & pain is generally temporary and more common in the first weeks of beginning treatment. Please ask for copies of available studies.

The nature of the chiropractic manipulation: We may use our hands, an instrument, or both, to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, certain complications may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare & can result from underlying weakness in the bones. Muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves or spinal cord (very rare), cerebrovascular injury, or stroke (very, very rare – chances are one in one million to one in ten million).

Ancillary treatments recommended: Ice, Moist Heat Packs, Ultrasound, Electrical Muscle Stimulations, Stretching/Strengthening Exercises, Massage Therapy, Diathermy, Laser, Neuromuscular Re-education, Graston Technique and Decompression Spinal Traction

Risks involved with recommended ancillary treatments: Ice, Heat & Electrical Muscle Stimulations (EMS) can cause burning. EMS can cause skin irritation underneath active pads. Stretching/Strengthening Exercises & Decompression can cause muscle strains. This list is not all inclusive.

Other treatment options can include: Medical care, prescription drugs, self management with over-the-counter medication, rest, and/or surgery.

Medical care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable side effects, usually more serious than those listed above, and the patient dependence increases in a significant number of cases. The material risks include but not limited to: addiction to medication, side effects of medication and improper self dosages.

Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and possibly include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of chiropractic adjustment and the related treatment. I have discussed it with the doctor 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 I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient name - Print	Patient Signature	Date
----------------------	-------------------	------

CONSENT TO TREAT MINOR - PLEASE FILL THE BELOW ONLY IF CONSENTING TO TREATMENT FOR A MINOR

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-noted minor, and hereby authorize **Oregon Spine and Disc** to administer treatment as it so deems necessary to the minor. If the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **Oregon Spine and Disc**, which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form. As of this date, I have the legal right to select and authorize health care services for the minor child named above.

Date: _____

Relationship to patient: _____

Witness: _____

Print Name (Parent/Guardian): _____

Social Security (Parent/Guardian): _____

Signature: _____