

Chiropractic Treatment - Informed Consent

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED
PRIOR TO YOUR 1ST APPOINTMENT**

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or maybe some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strain or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Further more, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name: (Please print name): _____

Signature of Patient or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

The vision of the Integrative Health Institute is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

I welcome professional dialogue regarding my case between members of my medical team at the Integrative Health Institute: Yes I No Signature: _____

Informed Consent for Chiropractic Acupuncture Care For Patients of Dr. Livia Chiarelli

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, and including electro-acupuncture by Dr. Livia Chiarelli.

I understand and am informed that in the practice of acupuncture there are some **risks to treatment** including, but not limited to, minor bleeding or bruising, minor pain/soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

IMPORTANT NOTICE:

The following **DO NOT** exist in my current state of health and I will immediately notify the practitioner of any changes:

- Taking blood thinners/anti-coagulants
- Have a bleeding disorder
- Have a blood borne disease
- At elevated risk of infection
- Have a local infection
- Have an internal heart defibrillator or pacemaker
- Have any metal plates/rods/screws/etc my your body

I have been advised that only pre-sterilized needles will be used and understand that all acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I understand that the results are not guaranteed.

I have read the above consent form thoroughly. I have also had an opportunity to **ask questions** about this consent, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

FEMALE PATIENTS:

I fully understand that in the case of **pregnancy**, there is a risk of fetal distress when an acupuncture treatment is performed without the practitioner's knowledge of the pregnancy. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Patient Name: (Please print name): _____

Signature of Patient or Guardian: _____ Date: _____