Equ.S.T. Chiropractic

CHIROPRACTIC CLINIC CONSENT TO TREATMENT

Whenever a patient is treated by a medical doctor, hospital, chiropractor, or other type of doctor there is always a possibility, no matter how remote, that the patient will not respond well or even undergo a negative response. When this happens it is almost always due to some overlooked or undetected factor in the patient's history or physical condition. While we can never reduce the risk of adverse reaction to zero, appropriate patient history and examination procedures can and do minimize the risk. Some areas of special concern are listed below**. Please initial that you have read and understand that it is your responsibility to make the doctor aware of any concerns that apply to you.**

Initial that I read:_____ PAST SURGERY: Any past surgery, especially recent surgery, and most especially any spinal surgery should be reported to the doctor during the initial consultation and patient history. Since the scar tissue after surgery is not as flexible as normal tissue, special care must be taken to avoid the possibility of aggravating the condition.

Initial that I read:_____ CARDIOVASCULAR: Any problems with the heart and blood vessels such as hardening of the arteries, high blood pressure, phlebitis, or any vascular trouble should be reported to the doctor so that special precautions can be taken to avoid the possibility of aggravating the condition.

Initial that I read:_____ FRACTURES AND DEGENERATIVE JOINTS: Fractures, degenerative joint disease and osteoporosis (which could lead to fractures) can all be detected on x-rays and will be explained and shown to you when x-rays are reviewed. Proper precautions will also be explained so that risk of further injury is avoided. Please inform the doctor if you have a fracture, degenerative joint disease or osteoporosis.

Initial that I read:_____ OTHER RISKS: It is impossible to include all potential risks. If there are any other concerns, please discuss them with the doctor before proceeding with care.

CONSENT TO TREATMENT

I wish to receive examinations and treatments at Equ.S.T. Chiropractic, PLLC; I have read and understand the above risks and precautions.

I understand the individuals respond differently to chiropractic treatment and that no guarantee can be given for the result of any treatment.

I therefore authorize examination and treatments to be performed by the doctor and/or staff at Equ.S.T. Chiropractic, PLLC.

_____ _____

PATIENT SIGNATURE DATE

_____

PARENT SIGNATURE (if minor)