Name: _____

DOB: _____

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.**

PAST SURGERY: Initial _____

Any past surgery, especially any spinal surgery, should be reported to the doctor. 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.

CARDIOVASCULAR: Initial _____

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. Special precautions will also be explained so that risk of further injury is avoided.

FRACTURES AND DEGENERATIVE JOINTS: Initial _____

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 if/when x-rays are viewed. Proper precautions will also be explained so that risk of further injury is avoided.

OTHER RISKS: Initial _____

It is impossible to include all potential risks. If there are any other concerns, please discuss them with the doctor, so we can proceed with care.

YOUR CONSENT TO TREATMENT

I wish to receive examinations and treatments at the Aspen Chiropractic Clinic; I have read and understand the above risks and precautions. I understand that 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 staff at the Aspen Chiropractic Clinic.

_____ _____

PATIENT SIGNATURE DATE

_____

PARENT SIGNATURE (if minor)