

# Aldrich Chiropractic Center

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## Informed Consent to Chiropractic Treatment

*Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.*

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or mobilization, are required to inform patients that there are or may be risks associated with such treatment. In particular:

- a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal therapy.
- b) There have been reported cases of injury to a vertebral artery following neck adjustments, manipulation and mobilization. Such vertebral artery injuries may on rare occasions cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication in an extremely rare event, occurring about 1 time per 1 million treatments.
- c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are very rare.

Treatments provided at the clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches, and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

**Acknowledgement:** I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

**Consent:** I consent to the chiropractic treatment(s) offered or recommended to me by clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature (Legal Guardian)

\_\_\_\_\_  
Signature of Guardian (when applicable)

Name:

\_\_\_\_\_  
(Please print name of patient)

Name:

\_\_\_\_\_  
(Please print name of guardian)

Name:

\_\_\_\_\_  
(Please print name of Witness/Translator)

\_\_\_\_\_  
Signature of Witness/Translator