Consent For Chiropractic Care

I hereby request that the doctors at Active Life Chiropractic and Wellness, LLC provide chiropractic services for me (or my minor child). I have read and understand the following:

1. The purpose of chiropractic care is the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.
2. Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis of medical conditions is not a primary goal.
3. The D.C.'s do not give, nor do they discourage me from receiving medical advice. If they deem it is advisable, they will refer me for medical advice.
4. Our D.C.'s use only chiropractic methods that are taught in accredited colleges and they will select appropriate techniques for my spine and the subluxations they find.
5. Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.
6. Although the risks are minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.
7. That because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.
8. That I am invited to ask any questions or express any concerns that I may have.
9. That I am free to present a written withdrawal of my consent and discontinue care at any time.

Print Patient Name ________________________________ Date ____________

Patient Signature: ________________________________ Date ____________

Parent/Guardian Signature: ____________________________ Date ____________

Witness: ____________________________________ Date ____________

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