



# AZARI CHIROPRACTICS

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**CHIROPRACTORS**

## INFORMED CONSENT

Chiropractic or osteopathic treatment, including spinal manipulation or adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective for spinal pain, some headaches, and other similar symptoms. Although no guarantee of treatment success can be given, chiropractic and osteopathic care have stood the test of time. The risk of injuries or complications from chiropractic or osteopathic treatment is lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

However, chiropractors, osteopaths, medical doctors and physiotherapists who use manual therapy techniques such as spinal manipulation or adjustments are now required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- a) Temporary soreness after treatment may occur in about 1 in 3 patients. Strains and sprains of the muscles, ligaments and other soft tissues do occur occasionally. While rare, some patients have also experienced rib fractures;
- b) There have been reported cases of injury to a vertebral artery following neck manipulation/adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury or death. The possibility of such injuries resulting from neck manipulation/adjustment is extremely rare;
- c) Although uncommon, there have been some reported cases of disc injuries following manipulation/adjustment of neck or lower back.

I acknowledge I have discussed, or if I so wish will have the opportunity to discuss, with my chiropractor or osteopath the nature and purpose of chiropractic or osteopathic treatment in general and my treatment in particular (including spinal manipulation) as well as the contents of this consent. I may do this at any time during my care.

I consent to the chiropractic or osteopathic treatments offered or recommended to me by my chiropractor or osteopath including spinal manipulation/adjustment. I intend this consent to apply to all my present and future chiropractic care. However, I may revoke or qualify this consent at a later time in writing. **This consent does not prevent me seeking damages for injury caused by negligent treatment.**

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Patient's signature

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Witness' signature

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Printed name

-----  
Printed name

Date signed: -----

(I consent to all procedures mentioned above except: -----)

Initialed: Patient:

Witness: