DR. JAY RAPPAZZO
INTEGRATED HEALTH SPECIALIST

Informed Consent to Chiropractic Treatment

There are risks associated with manual therapy. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stoke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustments is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatments.

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedure, including various modes of physical therapy, including acupuncture, decompression therapy, laser therapy, shockwave therapy, active release techniques and, if necessary, diagnostic x-rays on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic or staff member, the nature and purpose of chiropractic adjustments and other procedures, such as acupuncture, decompression therapy, laser therapy, shockwave therapy and active release techniques. I understand that results are not guaranteed.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustments), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractors including any recommended spinal adjustments.

I intend this consent to apply to all my present and future care in this office.

Date:_____

_____ _____

Patient Signature (Legal Guardian) **Witness Signature**

_____ _____

Name (please print) **Name (please print)**