Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including moist hot packs, rehabilitation, and various modes of soft tissue therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic listed below.

I have had an opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that chiropractic is a generally safe, conservative method of treatment, however as in the practice of bio-medicine, in the practice of chiropractic, there are some risks including but not limited to fractures, disc injuries, stroke (correlative only), dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise her judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic.

Female ONLY:
Are you pregnant or nursing? ☐Yes ☐No If *yes*, please check one: ☐pregnant ☐nursing

Patient's Name (PLEASE PRINT) **Patient's or Responsible Party's Signature** **Date**

If signed by Responsible Party, please provide below information:

Name (PLEASE PRINT) **Relationship to patient** **Witness**

BELOW IS FOR OFFICE USE ONLY

Allison Zang-Greene, D.C., Ac.

Clinician's Name (PLEASE PRINT) **Clinician's Signature** **Date**