# CONSENT FOR TREATMENT

Welcome to our Wellness Center,

Although you may be here for Physical Therapy, Medical and/or Chiropractic, for the sake of paper-reduction this consent mentions both of these health disciplines.

I hereby request and consent to the performance of physical therapy, chiropractic adjustments, physiotherapies, nutritional support, other procedures, and possible diagnostic X-rays/MRI, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic and/or Physical Therapist named below and/or other licensed Doctors of Chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Physical Therapist and/or Doctor of Chiropractic named below or with other office or clinic personnel the nature and purpose of physical/occupational therapies, nutritional support, traction, chiropractic adjustments and other procedures. I understand that results are not guaranteed.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedure s or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

Physical Therapy includes but is not limited to joint and spine mobilization/manipulation, dry needling, therapeutic exercise, neuromuscular techniques, muscle reeducation, hot/cold packs, and electrical muscle stimulation (e.g., cryotherapy, iontophoresis, electrotherapy) are modalities often used to expedite recovery in the orthopedic setting.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, nutritional support and physical therapies there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, drug interactions and sprains. I do not expect the doctor or therapist to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor or therapist to exercise judgment during the course of the procedure which the doctor or therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnor mal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, p resent to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic ca re may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one mill ion to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than the remedies listed above. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self -administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstance s and health care as you see fit

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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.

Patient Signature______________________________ Date ____________________

Witness Signature _______________________________________ Date_______________

Doctor-David Livingston, D.C. Therapists-Heather Preville: Alfredo Silva, L.M.T.