Carr Chiropractic Clinic – Dr. Samuel E. Carr

Informed Consent Form

I hereby give my consent to the chiropractic treatment and procedures, including tests to be conducted in managing my condition(s).

I understand that in such chiropractic treatment, the doctor will use his/her bare hands, including, but not limited to use of any mechanical device in order to move my joints.

I understand that in such movement of joints, I may feel and/or hear some popping of my joint(s). In such procedures, cold or hot packs may be used or muscle stimulant devices or therapeutic ultrasound.

I have been informed that in chiropractic treatment or management of conditions, such are the known risks:

Soreness or symptoms or Increased pain by which such may occur temporarily after the first few treatments.

Burns or bruises. With the use of devices, I understand that burns or temporary soreness or bruising might occur.

Nausea or dizziness. In this event where these symptoms are felt, I shall inform my chiropractor right away.

Fractures. It is my duty to notify my chiropractor in case I am aware that I have weak bones or have been diagnosed with any bone-weakening disease such as osteoporosis. The chiropractor may also halt the procedure if he or she finds that such or similar condition is detected by him or her while under the latter's care.

Spinal disc conditions like bulges or herniations. In such a case, I will have to notify my chiropractor when such symptoms arise.

Stroke. I am informed that there has been no known direct association between chiropractic treatments and stroke. However, for safety purposes, I shall inform my chiropractor of any symptom of neck pains and headache which are known symptoms of a stroke.

Finally, I understand that chiropractic treatment is not a perfect or exact science and is not an alternative method that guarantees results.

CONFIRMATION

I have read the information above regarding the chiropractic treatment, and it was discussed and explained to me by my doctor. I was given the opportunity to ask questions and all of which were answered to my satisfaction.

I have evaluated all risks and benefits about the treated, and I have decided to undergo the treatment recommended, and I hereby give my full consent to the treatment.

_____	_____
PATIENT NAME	DATE
_____	**Z** _____
PATIENT SIGNATURE	PATIENT NUMBER
_____	
WITNESS' INITIALS	