WEST END CHIROPRACTIC & REHAB CENTER

WEST END CHIROPRACTIC & REHABILITATION
4255 Laclede Ave.
St. Louis, MO 63108
Telephone: (314) 361-4650
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INFORMED CONSENT TO CHIROPRACTIC CARE

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Through chiropractic adjustments and treatments are usually beneficial and seldom cause any problem. I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

Chiropractic Adjustments, Electrical Therapy, Moist Heat, Cryotherapy (ie. Ice), Trigger Point Therapy, Massage Therapy, Neurological Muscle Re-education, Functional Activities, Rehab Exercises and Nutritional Consultation.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____