PATIENT INFORMATION

LARSON CHIROPRACTIC

Name

Address

City State ZIP

Phone Number Date of Birth

Height Weight

Employer Occupation

Email address

HEALTH HISTORY

When did this begin? What are your current symptoms, where is the pain?

Health History/Pre-existing Conditions

Have you been to a Chiropractor previously? For what conditions?

Medications Supplements

Are there any other health issues of concern?

I understand and accept that there are risks associated with chiropractic care and give my consent to the examination and to the chiropractic care including spinal adjustments.

Patient Signature Date

TURN OVER

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examination or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing as adjustment, we use or hands to reposition anatomical structures, such as vertebrae. 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 health.

It is important that you understand, as with all health care, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/ or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a clot with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million, to one in two million cervical adjustments. For comparison, the incident of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million people per year and the risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other that chiropractic care. Likely you have tried many of these approaches already. These options man 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 circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstances. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions for which I seek chiropractic care from this office.

PATIENT SIGNATURE_____ DATE_____

PARENT/GUARDIAN SIGNATURE_____ DATE_____