



Craig Weiner DC | 5405 Wilkinson Rd Langley WA 98260 | 360 331 5565

Informed Consent

Patient Name (Please print): _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal and extremity adjustments. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures which may occur at the office, at another clinician's office or at home.

- Spinal Adjustments
- Range of Motion Testing
- X-ray Studies
- Exercise Rehabilitation
- Palpation
- Orthopedic Testing
- Postural Analysis
- Postural Re-training
- Spinal Traction
- Basic Neurological Testing
- Hot/Cold Therapy
- Wobble Chair Exercise

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during spinal adjustments and rehabilitation. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examinations to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are extremely rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.



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The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization and/or surgery
- Complementary interventions such as massage, acupuncture and naturopathic care.

If you choose one of the above noted "other treatment" options you should be aware that there are risks and benefits of all such options and you may wish to discuss these with your primary medical physician and your complementary health care provider.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce the mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment; making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Craig Weiner and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient Name (Please print):

Doctor Name (Please print):

Patient Signature

Doctor Signature

Signature of Parent or Guardian if a minor: