BARKALOW CHIROPRACTIC AND ASSOCIATES
550 CAMINO EL ESTERO, STE 204
MONTEREY, CA 93940
PH: 831-375-5151
FX: 831-375-6682

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic listed above and/or with other office or clinic personnel.
I further understand and am informed that, as in all health care, in the practice of chiropractic, there are some very slight risks to treatment, including, but not limited to the following:

- • While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
- • There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. **The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;**
- • There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment;

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this ______ day of ___________, 20___.

______________________________ ______________________________
Patient Signature (or Parent/Guardian) Witness to the Signature

Name: printed______________________________ Name: printed ______________________________