

**VAN ZEILEN FAMILY CHIROPRACTIC PLLC**  
**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

**1)** I hereby request and consent to the performance of chiropractic treatments (also known as Chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

**2)** I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Although very rare, those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

**3)** I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

**4)** I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

**FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.**

☐ The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

**By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.**

**SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

\_\_\_\_\_  
Printed name of Patient

X \_\_\_\_\_

Signature of Patient

\_\_\_\_\_  
Date

X \_\_\_\_\_

Signature of Representative (if patient is minor or handicapped)

\_\_\_\_\_  
Date

X \_\_\_\_\_

Witness to Patients' Signature

\_\_\_\_\_  
Date

Patient ID# \_\_\_\_\_