SHAW CHIROPRACTIC
FAMILY WELLNESS CENTRE

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

There are risks and possible risks associated with manual therapy techniques used by Doctors of Chiropractic.

In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence there is a stroke already in progress. However, you are being informed of this reported association because stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

c) There are rare, reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment.

I acknowledge I have read this consent form and I have discussed or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general (including the spinal adjustment), the treatment options, and recommendations for my condition and the contents of this consent.

I hereby give my consent to the performance of chiropractic examinations, adjustments and other chiropractic procedures on me by any doctor named below at Shaw Chiropractic Family Wellness Centre. I consent to the treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Patient Name: _____ **Doctor**: *Dr. Stephen J. Bako, DC*

X _____ X _____

Patient / Guardian Signature Doctor

If you are the parent or legal guardian of a minor patient (under age 16) please sign on their behalf to provide consent.

Date: _____

X- Ray Consent

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Further, I certify to the best of my knowledge that I am **NOT** pregnant (if applicable). *I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.*

Patient / Guardian Initial: _____