SOUTHWESTERN CHIROPRACTIC and WELLNESS CENTER

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, examinations, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had opportunity to discuss with the doctors and/or with the office staff the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment may include, but are not limited to medical treatment, physical therapy and surgery.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, infection, and sprains.

I understand that I may be receiving the following treatment(s):

Intersegmental Traction	**Trigger Point Therapy**
Hot/Cold packs	**Electrical Stimulation**
Flexion/Distraction	**Ultrasound**
Cold Laser	**Acupuncture**
Home Exercises	**Cervical Traction**

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent the proposed treatment.

Signature of Patient: _____Date: _____

Signature of Patient or Guardian: _____ Date: _____

Witness to patient's Signature_____Date:_____