**Coleman Chiropractic**

**INFORMED CONSENT**

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Regular chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to, sprains, dislocations and fractures. In addition:

1. While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

1. There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.

1. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risks of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with the treating doctor of chiropractic of this clinic the nature and purpose of my treatment in particular including the benefits, risks and alternatives to chiropractic care.

I consent to the treatments offered or recommended to me by treating doctor and/or all doctors of chiropractic practicing within this facility, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from this clinic.

**Release from Work Policy**

Excuses from work are written on a per care basis. All excuses must be written before the date(s) of absences. No excuses from work or school will be written after the date(s) of absences.

Excuses must be signed by Dr. Brian D. Coleman, D.C.

Patients are not excused from work, any part there of, or on limited duty unless specifically stated in writing by Dr. Brian D. Coleman D.C.

My Signature below states that I have been made aware of the “release from work” policy of Coleman Chiropractic Clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Chart Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/Employee Signature Date