Consent to Chiropractic Care Form

Chiropractic care is recognized throughout the world as being an effective and extremely low risk method of care for both adults and children for many different conditions.

In adults and children the chiropractic adjustment (manipulation) of the spine is acknowledged internationally as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.) However as with all health care procedures there is a health risk which you are now required by law to be informed about. This form is not meant to scare or alarm you, it is simply an effort by this clinic to make you better informed and is done to satisfy legal requirements.

Chiropractic Care for a Child

The risks of a child experiencing an adverse reaction to chiropractic care is extremely rare and has been estimated at between 1 in 250 million and 1 in 700 million chiropractic adjustments.

The Government of Victoria (Australia) commissioned its agency Safer Care Victoria in 2019 to conduct an independent review titled *'Chiropractic Spinal Manipulation in Children under 12.*' The responses from the parents who participated were as follows:

21750 or 99.7% reported a *positive experience* with the chiropractic care of their children.

21474 or 98% reported that their child *improved after treatment.*

And only 0.3% of parents reported a negative experience. *(Importantly - NO serious adverse effects were reported).*

Chiropractic Care for an Adult

In adults chiropractic care is also a very low risk form of health care. However in extremely rare circumstances, some treatments of the neck may give rise to stroke or stroke-like symptoms (approx 1 in 5.85 million neck manipulations. (Haldeman, et al. Spine vol 24-8 1999). Whilst this has certainly never occurred in our practice, we are still required to advise you of these risks. Other very slight risks include strain /injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). (Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.) (see below for a comparison of other risks).

Risk Statistics Comparison

Death from General Anesthetic… 1 in 1250 (CJA, Sept 1999)
Hospitalisation for Gastrointestinal bleeding from Anti-inflammatory drugs… 1 in 250 (JMPT, Oct 1995)
Injury from Motor Vehicle Accident… 1 in 9300
Hospitalisation from Adverse Drug reactions… 20000 to 26000 per year (Aust. Jour. Hosp. Pharm, 1991,21(2)
Chances of being struck by lightening approx. 1 in 2 million

Please read the following carefully:

- ❑ I acknowledge that I have discussed with the treating Chiropractor the rare risks associated with my / my child's proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my / my child's underlying condition.
- ❑ I also acknowledge the following additional potential risks insofar as my / my child's proposed care is concerned have been explained to me. ……..
- ❑ I have also had the opportunity to discuss the proposed care with the treating Chiropractor and I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
- ❑ I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
- ❑ I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- ❑ I hereby acknowledge my consent to the performance of the proposed chiropractic care by ……. and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

Adult

…….. ……..
Patients signature Patients name (printed)

Child / Minor (*parent or guardian if patient is under 18)*

…… …….
Parents signature Childs name (printed)

Dated ……..

Office Use Only (*To be completed by DC or CA)*

……..
Witness to patient's signature

Dated ……

Privacy Statement

This practice collects your personal information to assist us in providing a service to you. We recognize and support your right to privacy in relation to this information, and will handle it with care and in accordance with our professional and legal requirements. We may be in touch to let you know about various services we offer or promotions which may be of interest to you. Please let us know if you object to this and if you prefer not to be contacted in relation to these. As a part of our privacy policy, we require your permission for the following:

*Please tick if you **do not agree** to the following:*

- ❑ To a thank you letter being sent to the person who referred you to us
- ❑ To your name being added to our referral board when you refer a new patient to us.
- ❑ To correspondence being sent to you via email.

The practice staff will demonstrate integrity and understanding by protecting and keeping secure your personal information. We invite you to read the Practice's "Privacy Statement" and to contact our privacy officer if you would like to discuss this matter further.