Patient's Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, computerized range of motion, examination procedures, including diagnostic x-ray on me (or on the patient named below, for whom I am legally responsible) by any licensed chiropractor who treats me at Mukilteo Chiropractic Clinic. I am responsible for informing the doctor if I am pregnant or might be pregnant PRIOR to having x-rays.

I will have an opportunity to discuss with my doctor and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that patients experience an audible "pop" during a manual adjustment and this is a normal part of treatment. Our doctors perform full spine adjustments, which may include area other than my chief complaint, in an effort to correct the biomechanics of my spine as a whole.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. According to research the probability of serious injury is 1:1,000,000. I understand that 40% on non-symptomatic patients have disc herniations, which may exist in my spine and become symptomatic whether or not I receive treatment.

I have read, or have had read to me, the above consent and I understand. I will also have an opportunity to ask questions about its content, and by signing below I agree to the above named procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) and for which I seek treatment.

Patient Name:_____Signature:_____Date:_____

If patient is a Minor, Physically or Legally Incapacitated
To be completed by Patient's Representative

Patient's Name:_____Name of Representative:_____

Date Signed:_____Signature of Representative:_____

Relationship or Authority of Patient's Representative:_____