Sherwood Family Chiropractic and Massage
Dr. Jennifer Nienaber DC; Dr. Samantha Stuart DC
Heidi Klein LMT lic.#:15439 Melissa Carlton LMT lic.#26732; RJ Sosa lic#20686
20508 SW Roy Rogers Rd C115 Sherwood, OR 97140 **503-906-3585**

INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION AND TREATMENT

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20508 SW Roy Rogers Rd C115 Sherwood, OR 97140 Phone:503-906-3585 Fax: 503-906-3586

Patient Name: _____DOB: _____ Date: _____

Chiropractic Examination

In order to provide an appropriate evaluation and treatment recommendations, a doctor will need to obtain a medical history from you and perform an examination. This examination will include palpation, where the doctor uses his hands on your spine, and/or other joints, and the surrounding soft tissue. Palpation allows the doctor to assess joint function and areas of subluxation. Your examination may also include other evaluations techniques such as: assessing your range of motion, orthopedic and neurological testing, imaging studies (like x-rays), obtaining your blood pressure and other relevant vital signs. Some portions of the examination may elicit or aggravate your pain or symptoms. It is important that you communicate all symptoms to the doctor and advise him/her if any portion of the examination causes you pain. All our patients are encouraged to ask questions before, during and after all aspects of the examination and subsequent care.

I _____ (print name), give my consent for examination.

_____ _____

Signature of Patient or Guardian Date

Chiropractic Treatment

Procedure: Chiropractic adjustment or manipulation is a manual procedure where the doctor uses his/her hands – or an instrument – to manipulate the joints of the body to restore or enhance joint function and mobility. You may hear an audible “pop” or “click” or feel or sense movement. Chiropractic care may include any of the following depending on your condition: chiropractic adjustments of the spine or other joints, manual muscle work such as massage, traction, ultrasound therapy, electric muscle stimulation (EMS), heat or cold therapy, the use of therapeutic exercise, cold laser light therapy and the use of nutritional counseling and supplementation. Your doctor will discuss with you a proposed treatment plan, which may at times be carried out by other doctors in the clinic or trained staff.

Risks: Chiropractic care, as in the practice of medicine and all healthcare, carries some risk during examination and treatment. Patients may experience temporary muscle soreness, inflammation, dizziness, worsening of symptoms with treatment, therapies or physical examination. Soreness following treatment, like that following exercise, should resolve within 24-48 hours. While the chances of experiencing serious complications are rare, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, burns or skin irritation from heat or other therapies, sprains/strains, disc injuries, dislocations or rib fractures following any manual technique. More serious complications are extremely rare. Vertebral artery dissection is associated with many neck movements, including chiropractic adjustments of the cervical spine. Current research indicates vertebral artery dissection is not caused by, but is associated with, cervical adjustment. According to some authorities, the association between cervical adjustments and vertebral artery dissection is one in a million (1 in 1 million).

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Vertebral artery dissections can lead to medical complications, including stroke. Additional information on side-effects, risks and complications is available upon request. If you have any unusual symptoms following treatment, you should immediately advise your doctor and seek care.

Patient Name: _____DOB: _____ Date: _____

Patient Participation: In order to provide you with the best recommendations and evaluate contraindications to care, it is critical you provide us with complete and accurate information about your medical history, symptoms, medications and changes in condition or symptoms. In some instances, it is important we coordinate your care with your other providers, and/or refer you to other specialists.

Alternatives: In addition to the alternative therapies offered by this clinic, other treatment options for musculoskeletal conditions may include rest, over-the-counter analgesics, prescription medications, injection therapies, acupuncture, physical therapy and surgery. Each of these actions carry their own sets of risks, some significant, and should be discussed in detail with your other healthcare providers. Remaining untreated may result in the formation of adhesions and reduced mobility, which can complicate future treatment and rehabilitation.

DO NOT SIGN BELOW UNTIL YOU HAVE MET WITH THE DOCTOR

I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms and will notify my doctor if there are any changes to this information. I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment.

Patient Name: _____Guardian Name: _____

_____ _____
Signature of Patient or Guardian Date

PARQ and discussion completed with patient:

Doctor Name: _____ Interpreter if applicable: _____

_____ _____ _____
Signature of Doctor Date