ALPHA OMEGA HEALTH CARE
INFORMED CONSENT FORM

Full Name: _____

Address: _____

D.O.B: _____/_____/_____

PATIENT INFORMATION

Changes in law now require all practitioners who manipulate the spine to warn patients of material risk. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (Approximately One in 5.85 million neck manipulations. Haldeman, et al. Spine vol.24-8 1999).

Other very slight risks include strain/sprain to a ligament or disc in the neck (Less than One in 139,000) or the low back (One in 62,000). (Dvorak study in Principles and Practice of Chiropratic, Haldeman. 2nd Ed.)

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than many other alternatives. (A risk Assessment of Cervical Manipulation, JMPT, 1995. Magna Report, Ontario Ministry of Health, 1993).

If you have any questions related to the treatment you are about to receive, please ask the Chiropractor before commencing treatment.

DECLARATION

In signing this form, I agree that I have read and understand the above information, that I have discussed the above information with the chiropractor, and that He/She has explained and answered any areas of the above information that I did not understand or had questions about. **By signing this form, I give my consent to care.**

In addition, I give my consent to the Chiropractor to access and acquire copies of any relevant information from other healthcare professionals, and to discuss my case where necessary with other relevant healthcare professionals.

Patient's Signature: _____ Date: _____/_____/_____

I also understand that Alpha Omega Health Care has the right to charge a fee, not exceeding the normal consultation charge, for a missed appointment or cancellation with less than 24 hours notice.

Patient's Signature: _____Date: _____/_____/_____

Chiropractor's Signature: _____Date: _____/_____/_____