Advanced Physical Health
Chiropractic • Physiotherapy • Rehabilitation
Kurt Spurgin Chiropractic, Inc.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of chiropractic, medical doctors and physiotherapist who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- While rare, some patients have experienced rib fractures, muscles strains and/or ligament sprains following spinal adjustments.
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- There have been rare reported cases of disc injuries following cervical and lumber spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments) as well as the content of this consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

TO BE COMPLETED BY PATIENT:

Date Signed: _____

_____ _____
Patient Name Signature

_____ _____
Staff Name Staff Signature

80-545 Highway 111 Suite B *Indio, CA 92201 *Phone:760-347-6822 *Fax: 760-347-8103 *email: kurtspurgindc@gmail.com