CANTON WEST CHIROPRACTIC

Informed Consent for Chiropractic Care

First Name *

Last Name *

Date of Birth *

Email *

CHIROPRACTIC CONSENT

Chiropractic care involves the examination, diagnosis, and treatment of conditions related to the spine, joints, muscles, and nervous system. Treatment may include spinal adjustments, joint mobilization, physical therapies, and other chiropractic procedures intended to restore proper movement and function.

Chiropractic adjustments involve the application of controlled force to specific joints of the body, primarily the spine, with the goal of improving mobility and reducing pain. While chiropractic care is generally considered safe and effective, I understand that there are some risks associated with treatment. These may include:

- Temporary soreness or discomfort
- Muscle stiffness
- Aggravation of existing symptoms
- Rare complications related to spinal manipulation

I understand that no guarantees have been made regarding the results of my treatment. I have had the opportunity to ask questions about my care and understand the nature and purpose of chiropractic treatment. I understand that I have the right to refuse or discontinue treatment at any time.

☐ **I agree to the terms of this Chiropractic Consent**

By signing below, I voluntarily consent to receive chiropractic care and treatment from Canton West Chiropractic and its healthcare providers.

Patient (or Guardian) Signature

Date