Informed Consent To Treat

I,_____, hereby request and consent to the performance of conservative, noninvasive chiropractic procedures, including spinal manipulation/adjustment and various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Dale Friar, Dr. Taylor Chard, and Dr. Michael Courson.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing, and x-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as an adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but can be performed by a hand-guided instrument, such as an Activator. During a spinal adjustment, you may hear a “click” or “pop,” such as the noise when a knuckle is cracked, and you may feel movement in the joint. This sound is created by gas escaping the joints upon movement and is completely safe. Very rarely and unlike many procedures, chiropractic care carries some risks. Some known risks are: soreness, bruising, nausea, dizziness, disc changes, muscle strain or sprain, or other risks not known. I understand that Dr. Friar, Dr. Chard, and Dr. Courson will exercise judgment during the course of my treatment and do what he feels is in my best interest, at the time, based upon facts known.

I have read or have had this informed consent document read to me. I understand that I will have the opportunity to discuss any questions or concerns with the doctors and will have my questions answered to my satisfaction. I have made my decision voluntarily and freely.

_____	_____
Signature	**Date**
_____	_____
Signature of Guardian if under 18	**Date**