Consent to Chiropractic Treatment

The Australian health practitioner's registration agency, (AHPRA) requires all practitioners who adjust or manipulate the spine, pelvis or cranium to warn patients of the material risks associated with such treatment. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to a stroke, or stroke like symptoms (approximately 1 in 5,850,000 neck manipulations, Haldeman et al., Spine vol. 24-8, 1999).

Whilst this has never occurred in our practice, we are still required to warn you. If any adjustments are required you will be tested beforehand, and your consent to proceed with the proposed treatment will be sought prior to treatment, as has always been our practice.

Other very slight risks include strain or sprain injury to a ligament, muscle or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000).

Chiropractic adjustments of the spine are internationally recognized as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A risk assessment of cervical manipulation; JMPT, 1995. Manga Report, Ontario Ministry of Health; 1993).

Many adverse reactions are the result of an underlying health condition or predisposed by other health factors, which is why it is important to inform the practitioner of any and all of your health problems. For example, a history of cancer or osteoporosis may predispose you to a fracture which is an important factor in the chiropractor's decision to undertake any treatment procedures. Any present or past medication must also be disclosed, as these may also have an adverse effect on the treatment outcome.

If you know you are at risk or think that you may be predisposed to suffering any of these effects due to an underlying condition please describe below:

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_____

Please read the following carefully, if you have any queries, do not sign until you have discussed your concerns prior to treatment:

- I understand that the practitioner will endeavour to minimize the risks of such events and reactions.
- I also acknowledge that I have the opportunity to ask questions about the nature, extent and purpose of care to be provided.
- I acknowledge that I am aware of the potential risk and I appreciate that like all health care modalities, results are not always guaranteed.
- I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- I hereby acknowledge my consent to the treatment and I understand that I can withdraw consent at any time.
- I understand there may be a considerable degree of variation in individual patient response.

Patients Name, First Name _____Surname _____

Parent or Guardian's name _____relationship to child _____

Patients Signature: _____Date:_____
(Parent or Guardian to sign if patient is under 18)

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