



INFORMED CONSENT

This office practices evidence based spinal care. This practice is based on nationally recognized practice guidelines as well as published research conducted at numerous universities and chiropractic colleges. Our commitment to you is to deliver the safest, highest quality of life changing care we can deliver focused on the reduction of spinal cord tension, spinal subluxations and to develop and maintain spinal and neural integrity.

To begin care, we need your consent to perform a history and physical evaluation focused on testing procedures and questions that solely relate to quality of life, stress levels, body awareness, spinal cord tension, spinal subluxations and the loss of spinal and neural integrity. The intent of your evaluation is to assess your current level of spinal and neural integrity. From there we will be able to create a plan to maximize your quality of life and degree of wellbeing.

We will not be performing a differential diagnosis to detect the presence of or determine target treatment for any disease, condition or symptom. The only diagnosis we will provide is that of spinal subluxation. If you desire advice, diagnosis or treatment for any symptom, condition, disease or concern we recommend that you seek the services of a health care provider who specializes in that area.

I _____ have read and fully understand the above statements. I understand that the spinal adjustments offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and nerve system integrity. This office offers chiropractic as a form of health and wellness care, to promote the natural mechanisms for self-healing and empowerment, as compared to specific target treatment. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____