

CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to myself while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications may include but may not be limited to: fractures, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications. The chiropractic profession has relied on comprehensive research to determine the level of risk associated with chiropractic neck manipulation and there is negligible evidence to support a causal relationship between cervical manipulation and vertebral artery dissection, which can lead to stroke. In fact, scientific studies have shown that neck manipulation (or chiropractic cervical adjustment) is safe, effective and appropriate for patients with common forms of neck pain and headache. An estimate of the odds of suffering a serious complication from a chiropractic neck adjustment are 1 in 5 million cervical manipulations. I do not expect the doctor to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I understand that I will have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Integrated Chiropractic Wellness, PLLC
Dr. Kristen Ude
1600 W. 38th Street Suite 412
Austin, TX 78731**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

SIGNATURE _____ DATE _____

[Consent to evaluate and adjust a minor child.]

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant
permission for my child to receive chiropractic care.

SIGNATURE _____ DATE _____