

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays 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 me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to : fractures, disc injuries, dislocations, muscle strain, Homer'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 including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

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 conditions for which I seek treatment.

**Bolt Chiropractic**  
**433 W. Channel Islands Blvd.**  
**Port Hueneme, CA 93041**  
**805-985-6867**

Print Name(s) of Doctor Treating This Patient

Dr. Donald Bolt, D.C.

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**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
VIC

\_\_\_\_\_  
Date