



Universal Chiropractic & Functional Rehabilitation

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INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to chiropractic care including examination, chiropractic adjustments and therapeutic exercise and modalities, such as ultrasound and electric stimulation, etc, the use of diagnostic x-rays on me, or the patient whom I am legally responsible, by Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, Dr. Duane Paterson or any other licensed doctor of chiropractic that may be employed in their absence.

I understand that chiropractic care involves the use of the hands to provide a chiropractic adjustment in such a way to restore proper motion to the joints. I understand that there are risks involved in chiropractic care just as there is in any health care. Some of the risks involved, but not limited to, are fractures, disc injury, sprains or strains, dislocations, and strokes.

These complications are generally regarded as rare. The subject of stroke and chiropractic adjustments has been subject to debate in and out of the profession, with one prominent authority saying that the chance of stroke is approximately one in one million adjustments (S. Haldeman, DC, MD). We employ tests in our exams that designed to identify if you may be susceptible to such an injury as stroke.

I have had an opportunity to discuss the possible risks and benefits with the doctor and I am aware that results are not guaranteed.

I have read or have had read to me the above consent form and intend that this form will cover the entire course of treatment for my present condition and for any future care that I may receive from Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, Dr. Duane Paterson or any other licensed doctor of chiropractic working in their stead.

Print Patient's Name:

Print Representative's Name:

Signature of Patient:

Signature of Representative:

Date Signed:

Relationship of Representative:

Witness:

Date Signed:

Date Signed: