WACHUSETT CHIROPRACTIC CLINIC
DR. STEVE D'AQUILA

CONSENT TO CHIROPRACTIC SERVICES

I, _____, date of birth _____ authorize the performance upon myself of the following procedure(s);

Examination and/or treatment

I realize that these procedures are to be performed by or under the direction of chiropractic physicians, employed by Wachusett Chiropractic Clinic.

Physicians, Chiropractors, Osteopaths and Physiotherapists using manual manipulation are required to advise their patients that:

1. With neck problems there have been rare incidents of injury to the vertebral artery during the course of treatment. These have caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 1 in 3 million treatments.
2. With neck or back problems there have been rare incidents of rib separation or fracture, bruising, swelling, or aggravation of symptoms.

APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOU RISKS

I hereby consent to the chiropractic treatment as indicated and explained to me. If during the course of treatment, unforeseen conditions are discovered or unusual conditions develop. I further consent to such additional diagnostic measures and treatment as may be indicated by sound and prudent chiropractic practice, which may require additional x-rays, chiropractic, orthopedic, neurological, and/or laboratory testing or consulting with another doctor.

No guarantee or warranty has been made to me that the results will be to my complete satisfaction.

I have read and understood the above statements and hereby give my consent to chiropractic treatment.

Date: _____ Signed: _____

Witness: _____ Relationship: _____