

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Shauna H. Christensen, DC, and/or Dr. Lauren Jetton who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for Shauna H. Christensen, DC, whether or not their names are listed on this form.

I understand and consent to the following procedures: (Checked below)

Examinations Nutrition Therapy Traction
 Adjustments Massage Therapy Electrical Stimulation
 Cold Laser Therapy Exercise Mobilization
 Heat/Cold Therapy Cox Table Adjustments

I have had an opportunity to discuss with Christensen Chiropractic the various types of treatment, including neck and spinal/extremity adjustments that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have had the opportunity to read this form, understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

PATIENT NAME (PRINT) _____ DATE _____

X _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor)

Office/Witness

Signature _____ Date _____

Dr Signature _____ Date _____

Christensen Chiropractic, INC
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