INFORMED CONSENT TO EXAMINE AND TREAT A MINOR

The word "*chiropractic*" is derived from the Greek words "*chiro*", meaning "hand" and "*praxis*", meaning "practice"; so chiropractic is literally healthcare *performed by hand*. As a patient at Portland Chiropractic Group, you should expect your child to be touched, moved, assisted, and adjusted by our doctors, and to a more limited extent, by our chiropractic assistants and massage therapists. Occasionally, complications may arise from the care we render. ***The purpose of this consent form is to inform you of the possibility of complications or adverse effects.*** Please read, initial, and sign the following consents to examination and treatment, permitting us to continue.

CONSENT TO EXAMINATION

Our chiropractic examination procedures include, but are not limited to, your child's health history, posture and range of motion evaluation, orthopedic and neurological testing, palpation of various body structures, spinal and extremity mobilization, manual or mechanical muscle testing and palpation, and referral for specialized testing such as blood evaluations, diagnostic imaging, and other tests.

> *On very rare occasions, physical symptoms may manifest or complications may arise during this examination. By initially here, _____, I authorize the doctor to examine my child to assess his/her health concern(s). This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.*

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CONSENT TO TREATMENT

Chiropractic therapeutic procedures include, but are not limited to, spinal and extremity manipulation/mobilization, manual or mechanical muscle therapy, exercise demonstration and prescription, physiotherapy applications such as ice, heat, ultrasound, and electrotherapy, referrals to other practitioners, nutritional recommendations, and advice on posture and home-based self-care.

The most common adverse effects of chiropractic treatment are short-term soreness and/or a temporary increase in pain. **The likelihood of initial soreness or increased pain has been found to be similar to that of starting an exercise program**[1]. In fact, a systematic review of the literature indicated **that most adverse events that could be attributed to spinal manipulation were benign and transitory**[2].

Fractures are rare and usually the result of an underlying bone pathology that we will try to assess during your history and examination. An event sometimes attributed to chiropractic manipulation is a stroke resulting from a cervical artery dissection[3]. This event is very rare, occurring at a frequency of between one per million and one per five million visits to a

[1] Bronfort et al., 2001; Hurwitz, Moregenstern, Vassilaki, & Chiang, 2005
[2] Gouvela, Castanho, & Ferreira, 2009
[3] Rothwell, Bondy, & Williams, 2001; Smith et al., 2003

chiropractic office. To date, no study has shown a causal relationship between cervical spine manipulation and stroke. Research has demonstrated that **a patient is as likely to have seen a primary care medical doctor as a doctor of chiropractic prior to experiencing a cervical arterial dissection[4].** In other words, the association of strokes and visits to either chiropractors or primary care physicians was equal, suggesting that the cause of the strokes could not be associated with any element unique to chiropractic care.

Naturally, we will discuss our treatment plan with you. We will also inform you of other options for care, to the best of our knowledge. Please note that all forms of healthcare include some form of risk. In fact, there are even risks to not receiving care that may include a worsening of your current complaint or development of other untoward complications.

Please read the above before signing this consent. If you have further questions or desire more information, simply ask and we will provide it.

> *Upon signing this form, I hereby request and authorize Dr. _____, and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to my dependent minor child. I also understand that there is no guarantee or warranty for a specific cure or result. I consent to examination and treatment of my child.*

As of today's date, I have the legal right to select and authorize health care service for the minor child named below.

Child's Name (printed):_____

Your relationship to child:_____

Legibly printed Parent/Guardian name:_____

Signature:_____ Date: _____

CUSTODY SITUATIONS

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent/Guardian Signature:_____

[4] Cassidy, et al., 2008