SADON CHIROPRACTIC & REHABILITATION CENTER
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Informed Consent Chiropractic

In the course of chiropractic health care, it is essential for the physician and patient to work towards the same objective. As a patient, you should understand the goal and methods of chiropractic mat will be used in order to avoid confusion or disappointment.

Adjustment:

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method, of correction is by specific adjustments of the spine.

Health:

A state of optimal physical, mental, and social well-being, not just the absence of infirmity.

Vertebral Subluxation:

A misalignment of one or more of the 24 vertebrae in the spinal column (which causes alternation of nerve function and interfere to the transmission of mental impulses), which can impair the body's ability to achieve maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area

We do not offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is adjusting to correct vertebral sublaxations.

I, ______________________________ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept Chiropractic care on this basis.

Patient Signature: ______________________________ Date: ____________

Informed Consent Physical Therapy

I, ______________________________ agree to undergo physical therapy evaluation and treatment at Sadon Chiropractic & Rehab. Center LLC, for my condition: ____________________

I understand that my treatment may include a combination of some or all of the following procedures: Therapeutic exercise and activity, therapeutic ultra sound, hot and/or cold packs, soft tissue mobilization, therapeutic electric stimulation, massage, stretching, joint mobilization, etc. The nature and purpose of all the above procedures will be explained to me prior to treatment. I am aware of potential temporary post-treatment symptoms which may include soreness, stiffness, and swelling, bruising and localized skin irritation. I understand that I may be asked to undress for the evaluation and treatment procedures. We will protect your privacy and modesty at all times to the best of our therapist's abilities by protective clothing and or draping and that every procedure will be explained to me in advance. I understand that I can refuse any procedure on the grounds of privacy and modesty protection

Patient Signature: ______________________________ Date: ____________