physiomobility HEALTH GROUP

Patient ID: _____

Chiropractic Treatment Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at Physiomobility Health Group.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I have been explained the risks and benefits of treatment. I understand that results are not guaranteed.

I understand and am informed that, Doctors of Chiropractic, Medical doctors and Physiotherapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment. In particular, potential risks may include but are not limited to:

a) While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation;

b) There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment or manipulation to the neck (cervical spine). Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck spinal adjustment or manipulation is extremely rare.

c) There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated chiropractic treatment to be effective for spinal pains, headaches, and other similar symptoms. Chiropractic care may contribute to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with other treatments, medications and procedures given for the same symptoms.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I am of legal age to give this consent.

Patient Signature_____Date _____

Doctor Signature_____Date_____

☐ ***Physiomobility*** DON MILLS
6 Maginn Mews, Suite 211
Shops at Don Mills
Tel: 416-444-4800
Fax: 416-444-4811

☐ ***Physiomobility*** THORNHILL
8150 Yonge St. Suite 1
Yonge & Uplands
Tel: 905-731-6777
Fax: 905-731-3336

☐ ***Physiomobility***
HOME HEALTHCARE
Central & North GTA
Tel: 416-444-9547
Fax: 416-444-4811

☐ ***Pain Management & Fibromyalgia Centre***
211-A- 6 Maginn Mews
Tel: 416-444-0699
Fax: 416-444-4811

physiomobility HEALTH GROUP

Patient ID: _____

Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments on me (or on the patient below, for whom I am legally responsible) by the practitioner named below.

I have the opportunity to discuss with the acupuncture provider the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize the physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of spontaneous miscarriage or pneumothorax.

I do not expect the acupuncture provider to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncture provider to exercise judgment during the course of the procedure which he/she feels, based on the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Provider's Signature _____ Date _____

☐ ***Physiomobility*** DON MILLS
6 Maginn Mews, Suite 211
Shops at Don Mills
Tel: 416-444-4800
Fax: 416-444-4811

☐ ***Physiomobility*** THORNHILL
8150 Yonge St. Suite 1
Yonge & Uplands
Tel: 905-731-6777
Fax: 905-731-3336

☐ ***Physiomobility***
HOME HEALTHCARE
Central & North GTA
Tel: 416-444-9547
Fax: 416-444-4811

☐ ***Pain Management & Fibromyalgia Centre***
211-A- 6 Maginn Mews
Tel: 416-444-0699
Fax: 416-444-4811