PAPE CHIROPRACTIC & WELLNESS CENTER

To the Patient: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure/treatment after knowing the potential risks involved. This disclosure is not meant to alarm you. It is simply an effort to make you better informed before any treatment is given.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy on me (or the name patient named below, for whom I am legally responsible).

I have had the opportunity to discuss my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives as well as the risk of not having any treatment with **Dr. Tianne A. Pape**.

I understand and I am informed that, in the practice of chiropractic there are some risks regardless of how unlikely or rare to treatment including, but not limited to. Muscle strains/sprains, fractures, disc injuries, strokes and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise his judgment during the course of treatment, which the doctor feels at the time, based on the facts known, and is in my best interest. I further acknowledge that no guarantee or assurances have been made to me concerning the results intended from treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

Print Patient's Name	Signature of Patient	DOB	Date

Print Parent/Guardian Name	Signature of Parent/Guardian	Date

Tianne A. Pape D.C, M.S		
Print Witness Name	Signature of Witness	Date

Informed Consent Form

Please answer the following questions to help us determine possible risk factors:

Question	Yes	No	Doctor Comments
General			
Have you ever had an adverse (i.e. bad) reaction to Chiropractic care?	____	____	_____
Bone Weakness			
Have you ever been diagnosed with Osteoporosis?	____	____	_____
Do you take corticosteroids? (e.g. prednisone)	____	____	_____
Have you been diagnosed with a compression fracture of the spine?	____	____	_____
Have you ever been diagnosed with cancer?	____	____	_____
Do you have metal implants?	____	____	_____
Vascular Weakness			
Do you take aspirin or other pain medication on regular basis?	____	____	_____
If yes, about how much do you take daily? _____			
Do you take warfarin (Coumadin), heparin, or other "blood thinners"?	____	____	_____
Have you ever been diagnosed with any of the following disorders?			
• Rheumatoid Arthritis	____	____	
• Reiter's syndrome, ankylosing spondylitis or psoriatic arthritis	____	____	
• Giant cell arteritis(temporal arteritis)	____	____	
• Osteogenesis imperfecta	____	____	
• Ligament hypermobility such as with Marfan's Disease, Ehlers-Danlos syndrome	____	____	
• Medical cystic necrosis (cystic muciod degeneration)	____	____	
• Bechet's disease	____	____	
• Fibromuscular dysplasia	____	____	
Have you ever become dizzy or lost consciousness when turning your head?	____	____	
Spinal Compromise or Instability			
Have you had spinal surgery?	____	____	
If Yes, when? _____			
Have you been diagnosed with spinal stenosis?	____	____	
Have you been diagnosed with spondyliolithesis?	____	____	
Have you had any of the following problems?			
• Sudden weakness in the arms or legs	____	____	
• Numbness in the genital area	____	____	
• Recent inability to urinate or lack of control when urinating	____	____	

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk (s) and alternatives to this care.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____