



HOPKINS CLINIC FOR PHYSICAL MEDICINE

*Providing Chiropractic
and Physical Therapy Rehabilitation Services*



INFORMED CONSENT

I hereby authorize the physicians and/or such assistant(s) as may be selected by the physician to treat me for my current complaints and physical conditions. The physician has explained to me the findings of the examination as well as the possible procedures necessary to treat my condition(s) by the physician and/or his assistants. The possible treatment procedures may include electric muscle stimulation, ultrasound, moist heat, application of cold packs, traction, various forms of soft tissue manipulation by the doctor or a physical therapist or licensed massage therapist, acupuncture, exercise rehabilitation therapy, biomechanical and postural recommendations and lifestyle alteration. If at any time you have any questions about any procedure in this office, please be sure to ask the doctor for more information.

The possible adverse effects during and after the application of physical therapy including thermal irritation to the skin from moist heat application or cold packs, pain or soreness from therapy such as massage and exercise therapy are reviewed. 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 on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. The very rare risk (3 per 10 million adjustments or 0.00025%)¹ of possible vertebrobasilar accident (stroke) associated with cervical manipulation is reported as is the rare possibility of major impairment (.639 per million) as a result of spinal manipulation². This has been disputed however in a review of current medical knowledge. ³The anticipated benefits of treatment can be pain reduction and improvement in ability to perform activities of daily living and/or occupational activities that are now restricted due to your current medial problems. Diagnostic procedures of x-rays (if necessary) and the associated risks and benefits will also be explained to me prior to having the procedure performed.

The possible results of not seeking care and potential natural resolution of the condition(s) has been explained to me. The subject of referral to another branch of the healing arts or physician for treatment or a second opinion is discussed. The possibility of failure of these procedures to relieve pain and/or resolve my condition(s) is discussed and no guarantee to resolve the condition(s) has been made to me by the doctor or his staff. I acknowledge that I have read this document in its entirety and that I fully understand it. I acknowledge that I was given ample time to review the document and an opportunity to ask the doctor or his staff any questions I may have concerning its contents. I am also instructed to ask any questions concerning my condition(s), tests or treatment at any time in the future if such questions should arise.

Patient Name

Patient Signature

Date

Witness

¹ Hurwitz, Spine, 1996; 21(15): 1746j-1760.
² Rand Study 1996.
³ Cassidy, Spine, 2008; 33(4S): S176-S183