Holladay Physical Medicine

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INFORMED CONSENT FOR EXAMINATION, PHYSICAL MEDICINE, CHIROPRACTIC MANIPULATION OR ADJUSTMENT AND RELATED PROCEDURES

I hereby request and consent to the performance of the chiropractic manipulation or adjustment and its related physical medicine procedures for myself (or for the patient named below, for whom I am legally responsible) by any physicians who now or in the future perform these procedures at Holladay Physical Medicine/The Personal Injury and Industrial Accident Clinic. This includes all forms of manipulation/adjustments, physiotherapy modalities, exercises, nutrition advice and other procedures related.

I acknowledge the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of this therapy. I understand that results are not guaranteed nor immediate. I understand and am informed that, as in the practice of medicine, the practice of chiropractic physical medicine and neuromusculoskeletal medicine carry risks; including but not limited to:

- Possible discomfort
- Pain
- Soreness
- Stiffness
- Possible increase in pain for up to 3 days
- Other risks have been reported but are extremely rare

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

physical examination,
palpation, vital signs
range of motion testing
orthopedic testing
neurological testing
muscle strength testing
postural analysis testing

Ozone/homeopathic injection
Ultrasound
hot/cold therapy
Electrical stimulation
cold laser
vibratory platform
treadmill

recumbent bicycle
vestibulo-ocular rehabilitation
radiographic and imaging studies
Laboratory testing
spinal and/or extra manipulative therapy

I understand and acknowledge that no one at this office has made any representations or claims to me of any treatment or cure of any disease or condition, or any promise of any specific or general results of any kind. I release from all general, medical and any other liability or claims of any kind.

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's Name: _____

Signature: _____ Date: _____