3 Waterloo Street
New Hamburg, ON N3A 1S3
Tel: 519-662-2123
wecare@affinityhealthclinic.ca

Informed Consent to Chiropractic Examination and Care

In order for the Doctor of Chiropractic to make a determination on the suitability of my case for chiropractic care and to make decisions about my care, I acknowledge that I must receive a thorough chiropractic health examination. I hereby request and consent to the performance of such an evaluation. I also hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, massage therapy, acupuncture and various modes of physical therapy and, if necessary, diagnostic x –rays, on me by the doctor of chiropractic, named below and/or anyone working in this center authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic, named below and/or with other office or clinic personnel, the nature and purpose chiropractic adjustments and other procedures including acupuncture. I understand that results are not guaranteed.

I further understand and am informed that, as in health care, in the practice of chiropractic there are some risks to examination and treatment, including, but not limited to, short term aggravation of symptoms, muscle and ligament strains or sprains, disc injuries, and strokes. Although rare, rib fractures have been known to occur. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke. Rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke; essentially there is a stroke already in progress. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. I hereby agree that I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. I intend this consent to cover the entire course of treatment for my present condition.

I also understand that the contents of my file may be accessed by any of the registered health practitioners listed below and their support staff.

PRACTITIONER:

- **Dr. Gary Hamilton, D.C.**
- **Dr. Sara O'Neill, D.C**

TO BE COMPLETED BY PATIENT:

_____ _____

PRINT PATIENT'S NAME SIGNATURE OF PATIENT
(or parent if patient under 18 yrs.)

Date Signed: _____

_____ _____

WITNESS NAME SIGNATURE OF WITNESS

Date Signed: _____