Chiropractic Treatment Consent Form

Alyssa M. Guglielmo, DC, CACCP
Living Well Holistic Health, LLC
565 NJ-35, Suite #1
Red Bank, NJ 07701

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including the examination, and ancillary treatment for me (or for the person named below, for whom I am legally responsible) by the Doctor named herein, or other licensed Doctor who now, or in the future, will render care at this clinic.

I will have the opportunity to discuss with said Doctor the nature and purpose of chiropractic adjustments and other procedures, I understand, of course, that results cannot be guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks involved, though rare. They may include but are not limited to: fracture, disc injury, cervical dissection, stroke, dislocation, sprain/strain, or possible aggravation of the pre-existing condition which are designed to identify if the patient may be susceptible to that kind of injury.

If the Graston Technique is performed, I understand that a common side effect is bruising. Though controlled, this may last for several days and I understand that topical pain relief cream and ice may help to ease any soreness.

I have read, or have had read to me, the above consent form. If interested, I will have the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures and to not hold the treating doctor liable if any side effects do occur. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Date Patient Signature

_____ _____

Witness Signature Signature of Parent/Guardian