

Chiropractic Adjustment Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Consent for Chiropractic Adjustment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and support staff.

☐

I have been informed about the risks and benefits of chiropractic treatment.

☐

All my questions regarding procedures have been answered to my satisfaction.

Health History

Please list any existing medical conditions or previous injuries

Current Medications

Allergies

Consent & Signature

Patient/Guardian Signature

Date

Doctor's Name
