

Reisterstown Family Chiropractic

Terms of Acceptance

File #: _____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working on the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Although the incidence of complications associated with Chiropractic services is very low, potential risks may include: fractures, disk injuries, stroke, dislocations, and those that relate to physical aberrations unknown or reasonable undetectable by the chiropractor.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system, and overall body function. Subluxations cause alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

If during the course of our chiropractic spinal analysis, we encounter unusual findings, we will let you know of them. You may decide then whether you wish to investigate further and discuss your options with other healthcare professionals.

The purpose of chiropractic care is not to treat diseases or conditions directly, nor to get rid of pain, but to help your body function better by removing spinal nerve stress (subluxations). Therefore, we do not prescribe surgery or medication. If you wish to decrease or stop your medications you should discuss that with your family doctor.

Our goal is to help your body eliminate a major interference to the expression of your physical/emotional health and healing – vertebral subluxations – so that your natural healing ability may function without this severe form of stress and you may reach more of your health and wellness potential.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic Care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to that best of my knowledge I am not pregnant and the above named doctor and his/her associates/staff have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature

Date