INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

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I hereby request and consent to the chiropractic services of Teresa Yin, D.C. and/or associated licensed doctors and/or authorized persons who might now or in the future treat me while employed by, working or associated with, or serving as a back-up for Dr. Yin in an attempt to improve my physical condition.

I understand the purpose of this and subsequent visits are to acquire chiropractic care. A natural and conservative approach to my health needs, chiropractic care utilizes manipulation or joint adjustments, exercise, nutrition, and various modes of physiotherapy.

I understand that a definitive diagnosis may require further test (e.g. x-rays, laboratory test, MRI, etc.) and/or referrals to other health care professionals. Although Dr. Yin and her associates may prescribe or suggest these tests or referrals, it is my responsibility to schedule an appointment and to acquire these test and/or referrals.

I understand and am informed that some risks are associated with chiropractic treatment, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes, and paralysis. I do not expect Dr. Yin and/or her associates to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on her judgment during the course of the procedures, which she feels is in my current best interests.

The body's (nervous and musculoskeletal systems) reaction to Dr. Yin and any associated licensed professional's chiropractic treatments may be a generalized soreness over and around the area of my chief complaint. This is a normal and expected result because the muscles in the area have been stressed (spasm) and the bones misaligned. During my treatment, Dr. Yin and any associate provider will be releasing stress on my spine, bones, joints, and surrounding soft tissues (e.g. muscles, tendons, ligaments, bursae, and nerves). This process breaks up the pain and spasm cycle in my body, but in doing so, my body may require time to adjust to these physiological changes.

I understand that I am responsible for monitoring my own condition throughout the treatments and will inform Dr. Yin and any associated medical provider of any unusual symptoms that might occur.

In signing this informed consent form, I affirm that I have read this form in its entirety and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic treatment, the management of my case, and the related risks to chiropractic treatment has been answered to my satisfaction.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient Signature: _____ **Date:** _____ / _____ / _____