



**CHARLESTON™**  
**Neck & Back**  
**C E N T E R**

**INFORMED CONSENT**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

West Ashley  
 1835 Savage Road  
 Charleston, SC 29407  
 (843) 763-2225  
 Fax (843) 763-3433

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.
- b) 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 the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
- c) There are rare reported cases of disc injuries identified following cervical and lumbar manual therapy, although no scientific evidence has demonstrated such injuries are caused or may be caused by spinal adjustments or other chiropractic treatment.
- d) There are infrequent reported cases of burns or skin irritation in association with use of some types of electrical therapy offered by doctors of chiropractic or physical therapists.

Ralph D. Roles, D.C., D.A.C.A.N.  
 Board Certified  
 Chiropractic Neurologist

Joseph W. Barlett, D.C.  
 Board Certified  
 Chiropractic Physician

I acknowledge that I have read this consent and I have discussed, or have been offered the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of the Consent.

I consent to the chiropractic treatment recommended by this office including any recommended spinal adjustments. I intend this consent to apply to any present and future chiropractic care unless withdrawn in writing my myself.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2018

\_\_\_\_\_  
 Patient Signature (Legal Guardian)

\_\_\_\_\_  
 Witness of Signature

Name: \_\_\_\_\_  
 (please print)

\_\_\_\_\_  
 Patient Account Number