



**Alpenglow Acupuncture, LLC**

**Chiropractic Treatment Informed Consent Form**

Patient Name/Guardian: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

It is important for a patient seeking chiropractic health care to understand both the objective of care and the method of treatment. After being advised of the known benefits, risks and alternatives, you have the right to be informed about the condition of your health and the recommended care and treatment so that you may make an informed decision about whether or not to undergo chiropractic care.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the vertebrae in the spinal column become misaligned and/or restricted in movement. This can cause alteration of nerve function and interference to the nervous system. There may be pain and dysfunction associated with a vertebral subluxation or it may be asymptomatic. Subluxations are corrected by an adjustment performed manually, or with a handheld instrument. An adjustment is the specific application of forces to restore movement and function to the spine at the area being adjusted. In addition, chiropractic care may include ancillary procedures such as physiotherapy and other rehabilitative therapies. If during the course of care we encounter non-chiropractic or unusual findings, the Chiropractor will advise you of those findings and recommend that you seek the services of another health care provider. Chiropractors practicing at Alpenglow Chiropractic are licensed by the State of Alaska and practice within the scope of practice set forth by the Alaska State Board of Chiropractic Examiners.

All questions regarding the benefits and risks of chiropractic and the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

**Signature required for treatment:**

**Patient or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Chiropractic Consent to evaluate and adjust a minor child:** I, \_\_\_\_\_  
being the parent or legal guardian of \_\_\_\_\_ have read and fully  
understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Parent or Guardian's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness