Alliance Chiropractic
A Functional Wellness Center

Patient Consent Form

I hereby request and voluntarily consent to the performance of chiropractic treatments and/or other services related to chiropractic including various modes of physical therapy and diagnostic procedures, on me or a minor, for whom I am legally responsible for. This consent is given to the doctors and practitioners at Alliance Chiropractic, located at 552 S. Washington St. Suite 120, Naperville, IL 60540

I understand that this office utilizes many forms of diagnosis and therapy including but not limited to:

- Physical Exam
- Chiropractic manipulation including Webster Technique, Acupuncture and/or dry needling, kinesiology taping
- Soft tissue manipulation: massage, visceral manipulation, massage, cupping, and instrument assisted soft tissue therapy
- Therapeutic exercises: McKenzie therapy, corrective exercises and stretches, strengthening exercise
- Medical use of nutrition: therapeutic nutrition, nutritional supplements and botanical medicine
- Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, work/life balance
- Preconception counseling

No Guarantee: I understand that results are not guaranteed and depend on adherance to the recommended treatment plan(s).

Recital of Risks: I understand and I am informed that, in the practice of medicine, there is some degree of risk to treatment. Within the general healthcare setting for services from doctors and practitioners, the possible outcomes of these practices range from minor to fatal. A verbal or written list of possible risk from therapies provided may be obtained if requested.

I understand that some herbs and supplements, and some treatment modalities, may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant or have another condition of which he/she is unaware.

I will inform the doctor and/or practitioner if I experience any gastrointestinal upset (e.g. nausea, gas, stomach ache, vomiting), allergic reactions (e.g. hives, rashes, tingling of the tongue, difficulty breathing, headache), or any unanticipated or unpleasant effects associated with any treatment modality, herbs, or supplements. I understand that while this document describes the major risks of treatment, other side effects and risks may occur (e.g. muscle cramping, muscle soreness). I do not expect the doctor or practitioner to be able to anticipate and explain all risk and complications, but I wish to rely on the their judgment during the course of any treatment and their intent to act in my best interest.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to proceed with treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have discussed treatment options and goals, risks of various treatment options, and alternative treatments with Dr. Jessica Leighton, DC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, benefits, and alternatives I hereby give my consent to that treatment.

Patient Name ______________________________

____
Patient Signature Date

____
Signature of Parent or Guardian (if a minor)

____
Dr. Jessica Leighton Date