# INFORMED CONSENT TO CHIROPRACTIC CARE

## Hajime Yajima, D.C.

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the doctor of chiropractic named above.

I will have the opportunity to discuss with the doctor the purpose and benefits of the chiropractic adjustments and other treatments. Alternatives to treatment will be reviewed.

Though chiropractic adjustments and treatments are usually beneficial and rarely cause any problems, I do understand that there are some risks to treatment. Risks include but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

I understand that chiropractic is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance will be made by anyone regarding the chiropractic treatment that I can request or authorize. I confirm I have taken the opportunity to read this form and can ask questions at any time. I consent to any proposed treatment.

**** Please discuss any questions or concerns with the doctor. ****

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Witness Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____