

VIC Informed Consent Minors

Informed Consent to Chiropractic Care for Minors

Valley Integrative Chiropractic Informed Consent to Chiropractic Care for Minors

At Valley Integrative Chiropractic, we believe that your health decisions should be made with clarity and confidence. Our role is to provide you with the information you need to make informed choices about your care. This process is known as "informed consent."

1. Nature of Chiropractic Care

Chiropractic care involves the use of manual or instrument-assisted adjustments to restore motion and function to joints in the spine or extremities. These adjustments may result in an audible "pop" or sensation of movement. We may also recommend supportive therapies including but not limited to:

- Electrical stimulation
- Ultrasound
- Low-level laser therapy
- Traction
- Heat or ice
- Rehabilitative exercise or movement therapy
- Soft tissue therapy or massage
- Nutritional consultation or supplementation
- Lifestyle and ergonomic recommendations
- Emotional or mind-body techniques (e.g., neuro-emotional work)
- Applied kinesiology testing or techniques
- Instrument-based adjustments (e.g., Torque Release Technique)

2. Benefits of Care

The potential benefits of chiropractic care include improved joint motion, decreased pain, reduced inflammation, improved nervous system function, and enhanced overall well-being. While many patients experience meaningful improvements, no specific outcomes can be guaranteed.

3. Risks and Complications

As with any healthcare procedure, chiropractic care carries some risks, including but not limited to:

- Temporary soreness, stiffness, or muscle spasm
- Sprains, strains, or bruising
- Aggravation of existing conditions
- Disc or nerve irritation

- Rib or bone fracture (especially in patients with osteoporosis)
- Rare complications such as vascular injury or stroke

4. Stroke and Arterial Dissection Risk

There is an extremely rare risk of arterial dissection leading to stroke. This may occur spontaneously or be associated with everyday activities such as turning the head or sneezing. Current evidence does not support a causal link between chiropractic adjustments and arterial dissection in healthy arteries. However, symptoms such as severe headache, dizziness, blurred vision, or loss of balance should be reported immediately.

The warning signs of vascular events include the "5 Ds and 3 Ns":

- Dizziness
- Drop attacks
- Diplopia (double vision)
- Dysarthria (speech difficulty)
- Dysphagia (difficulty swallowing)
- Nausea
- Numbness
- Nystagmus (rapid eye movement)
- Ataxia (loss of coordination)

5. Alternatives to Chiropractic Care

You may choose alternative treatments including:

- Self-care and rest
- Over-the-counter or prescription medication
- Physical therapy
- Injections
- Acupuncture
- Surgery
- Psychological or stress management therapies

You also have the right to seek a second opinion at any time.

6. Technique and Contact Considerations

Some examination or treatment techniques may involve physical contact near sensitive anatomical areas, such as the lower back, sacrum, or pubic bone. When clinically indicated, procedures may involve contact over clothing to these regions or guided tissue work to muscles or ligaments in the pelvic or abdominal region. Your comfort and consent are always prioritized.

At times, certain procedures may require direct contact with the skin (such as during muscle testing, cranial work, or emotional reflex points), but these do not involve sensitive regions unless explicitly discussed with you beforehand. Any contact of a more intimate nature will always be explained thoroughly, require your verbal agreement at the time, and may be declined without impacting your care.

7. Consent to Treat

I understand the nature of chiropractic care, its benefits, risks, and alternatives. I have had the opportunity to ask questions and have them answered to my satisfaction. I consent for my minor to receive chiropractic care, including adjustments and supportive therapies, as deemed appropriate by the provider. This consent applies to the entire course of care now and in the future.

Parent or Guardian of Minor Child

I am the parent or legal guardian of the above-named patient and authorize the performance of chiropractic care and any necessary examination or therapy. By signing, I affirm I have the legal right to make these decisions.

X

Print name:

Date: