



## **Informed Consent to Chiropractic Exam and Treatment**

I hereby request and consent to undergo a chiropractic exam and chiropractic adjustments, performed by Dr. Brittany Jauernig, DC. I have had an opportunity to discuss the benefits, risks, and alternatives to Chiropractic care with Dr. Brittany Jauernig, DC.

I understand that benefits of chiropractic Care may include decreased pain, increased motion and energy, faster healing time, less chance of invasive measures such as drugs or surgery, etc. I am aware that chiropractic Care does pose some small risks, including, but not limited to, sore muscles, sprains, fractures, and strokes. I understand that alternatives to Chiropractic care may include massage, physical therapy, acupuncture, yoga, or referral to a medical physician.

I have read the above information and have had an opportunity to share any questions or concerns I have with Dr. Brittany Jauernig, DC. By signing below, I give my consent to a chiropractic examination and chiropractic adjustments. I intend for this consent to cover my entire course of treatment with Dr. Brittany Jauernig, DC.

Patient Name (printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(in case of a minor)