Please read this entire document prior to signing it. It is important to understand the information in this document, please ask questions before signing anything is unclear.

The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy. Dr. Nixon may use her hands or a mechanical instrument upon your body in such a way as to move your joints into normal alignment, this action may cause a "pop" or "click," much as you have experienced when you "crack" your knuckles. This sound is a byproduct of fluids and gases moving in your joints and does not indicate if the procedure was successful. You may or may not feel a sense of movement.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor named below and any other licensed doctor of chiropractic who now or in the future may work at Back in Motion Chiropractic.

I understand and am informed that, as in the practice of any medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

Other treatment options available elsewhere for my condition may include:

- Self-administered, over-the-counter pain relievers, and rest
- Prescription drugs such as anti-inflammatories, muscle relaxers and pain killers
- Hospitalization and/or surgery

If I choose to use one of the above noted "other treatment" options, I understand I should be aware that there are risks and benefits of such options and should discuss these with the treating doctor.

Allowing my condition to remain untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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 the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

Patient Name: _____

Patient Signature_____ Date _____

Doctor Signature _____ Date_____

Elizabeth Nixon, D.C.

A note from Dr. Nixon: I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.