



Cayman Physiotherapy Ltd.

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Paediatric Chiropractic Intake form – Consent

Baby's Name _____ DOB DD / MM / YYYY Gender ☐ M ☐ F
Parent's Mobile _____ Parent's Email _____
Insurance company _____ Member ID/Certificate no. _____
Group/Policy no. _____ Company name (under which policy is registered) _____

Informed Consent to Chiropractic Treatment for Children and Babies

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. For children and babies the amount of force and technique used is dependent on age, and is different than for adults.

Your chiropractor will explain the technique used for your child, the rationale, expected outcomes and risks.

In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

****PLEASE TURN OVER****

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent. I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

☐ I certify that the above medical information is correct to my knowledge

Privacy and Sharing of Information –Required

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

AUTHORIZATION FOR CARE OF A MINOR –Required

I DECLARE I AM THE LEGAL GUARDIAN, AND HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY.

☐ I agree

CONSENT FORM FOR BREASTFEEDING MOTHERS –Required

I understand that during the course of treatment of my baby that the baby may need to breastfeed and that the chiropractic examination and treatment will involve breastfeeding observation. For mothers who are experiencing blocked ducts or blebs, a separate history and consent will be needed to treat the breast tissue of the breastfeeding mother.

Parent's Name(s) _____

Signed _____ Date DD / MM / YYYY