Terms Of Acceptance

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum potential.
Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose, treat, or attempt to cure any disease or condition other than a vertebral subluxation. If you desire advice, diagnosis or treatment about symptoms and conditions we suggest that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to assist the body in removing interference to the spine and nerve system and our only method is specific adjusting to correct vertebral subluxation.

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

I, _____ have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care with this office have been answered to my complete satisfaction and are hereby authorizing C.A.F.E. of Life Chiropractic, Inc. to proceed with any services that may be deemed necessary. I therefore accept chiropractic care on this basis.

_____	_____	_____	_____
(Patient Signature)	(Date)	Witness (Office Staff)	(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____(Minor's Name) have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. I further authorize the minor to complete and sign any documents at this office which are customarily completed and signed by patients at your practice as a condition of treatment, and such signature shall serve as my own. In no event shall my signature to any other document have any effect on this consent form.