

PATIENT INFORMED CONSENT

I hereby indicate my wish to participate in the treatment program offered by APMR.

I understand that the purpose of this program is to enhance my overall health and fitness. Exercises may include stationary cycling, weight lifting, and stretching to improve flexibility, and joint range of motion. I understand that exercises can cause stretching and straining of muscle tissue, which can result in a temporary level of soreness.

I understand that medications may be prescribed to improve my overall health. I understand there exists the possibility that certain reactions or abnormal changes may occur while taking medications. These changes could include abnormal heart beats, abnormal blood pressure response, serious muscle and joint pains, rashes, allergic reactions, loss of consciousness, and in some case death. Professional care throughout the entire program should provide appropriate precautions against such problems. I understand that chiropractic treatment may be prescribed to improve my overall health. I understand that chiropractic treatment is considered the safest of all the major healthcare systems. I understand there exist a possibility that certain reactions or abnormal changes, although rare, could occur. These changes could include muscle and joint strain, fracture, dizziness, abnormal vascular response, impeding blood flow in vertebral arteries.

I verify that my participation is fully voluntary and no coercion of any sort has been used to obtain my participation. I have read the above information and understand it fully. Questions concerning these procedures have been answered to my satisfaction. I understand that I am free to deny answering any questions during the evaluation process or to withdraw from the program at anytime. The information that is obtained from this process is confidential and will not be discussed with anyone other than my physician.

Signature of Patient:

Date:

Patient ID#: _____