

INFORMED CONSENT TO CHIROPRACTIC / SOFT TISSUE CARE

I hereby request on my behalf (or the behalf of the patient named below for whom I am legally responsible) the performance of chiropractic adjustments and other procedures including various modes of physical therapy, nutritional therapy, and necessary diagnostic procedures such as, but not limited to, x-rays, laboratory blood and urine analysis.

I consent to these procedures/care being performed on by the Doctor of Chiropractic or by associates with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations and sprain. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, and is in my best interest.

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) for which I seek treatment.

**Muscle Works
Paul Guerrero, D.C.**

410 S. Glendora Ave Ste 130
Glendora, CA 91741

707 Escondido Ave. Suite 108
Vista, CA 92084

**(To be completed by patient's representative if
patient is a minor or physically or legally
incapacitated)**

Patient's Name (print)

Patient's Name (print)

Signature of patient

Representative's Name (print)

Date Signed

Representative's Relationship to patient

Signature of representative

Date Signed