

DR. MICHAEL TERE0 // PRACTICE OF CHIROPRACTIC AND NUTRITION

510-944-4794 // drmtere0@gmail.com // www.DrTere0.com

INFORMED CONSENT FOR EXAMINATION AND TREATMENT (CHIROPRACTIC):

I hereby agree to the performance of such examinations, procedures, and/or treatments as in the opinion of Dr. Tere0 is deemed necessary on myself. Dr. Tere0 employs standard chiropractic examination methods which include: **1.**

Observation; a general assessment/appraisal in all positions. **2. Inspection;** viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, and back sides. All symptomatic (painful) parts may be viewed. Women may continue wearing their bra during the examination unless it obscures visualization/viewing of injured/abnormal body parts. Women may request a female observer be present at any time. **3. Auscultation;** Using a stethoscope to listen for blood pressure and other body sounds. **4. Palpation;** the doctor will touch you to feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity, and abnormality. **5. Percussion;** using a rubber hammer and tapping on bones and tendons. **6. Orthopedic/Chiropractic testing;** these are standard tests to assess your neuro-musculo-skeletal systems. *NOTE: you do not have to submit to any examination procedure. I ask you to comply to the best of your ability and report any changes in pain. All procedures are accomplished to your tolerance.*

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, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgement during the course of the procedure to which the doctor feels at the time, based upon the facts then known, is in my best interests.

NOTICE OF UNDERSTANDING AND AGREEMENT (NUTRITION) : I hereby attest to the following:

1. I fully understand the Practitioner I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Practitioner are at all times restricted to helping me gain a better understanding of my degree of "health" not disease, so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

I, _____, have read and understand the above.
(print name)

Signature: _____ Date: _____ Referred by: _____