

**Family Chiropractic & Nutrition**  
1123 Fannin, Columbus, TX 78934 - (979) 733-9500

**PERMISSION & AUTHORIZATION FORM  
CONSENT TO TREAT**

**PLEASE READ BEFORE SIGNING:**

I specifically authorize the natural health practitioner at Family Chiropractic & Nutrition to perform a Nutrition and Chiropractic Analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, chiropractic manipulations, etc. in order to assist me in improving my health, and **not for the treatment, or “cure” of any disease.**

I understand that **Nutrition and Chiropractic Analysis is a safe, non-invasive, natural method** of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that Nutrition and Chiropractic Analysis is not a method for “diagnosing” or “treatment” of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition and Chiropractic Analysis or any natural health, nutritional or dietary programs recommended, but rather I understand that the Analysis is a means by which the body’s natural reflexes can be used as an aid to determining possible nutritional and skeletal imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that chiropractic manipulation may have risks, however rare. Complications may include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The risk of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from taking a single aspirin tablet.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_

(If minor, signature of parent or guardian required)

Witness: \_\_\_\_\_