I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments, the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, burns and aggravation of disc injuries.

I understand that if I receive acupuncture and oriental medicine treatments the risks included but are not limited to: minor bleeding, local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. 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.

Patient's Signature	Patient's CIN:	Date

Print Last Name	First	Middle

California State University, Los Angeles
STUDENT HEALTH CENTER

AUTHORIZATION AND CONSENT FOR CHIROPRACTIC TREATMENT

Last Name_____

First_____

CIN_____