

HEINEN PHYSICAL THERAPY, PLLC

Consent to High-Velocity Low-Amplitude Thrust Manipulation

1. I, _____ am at present in good health.
(Print Name)
2. I understand that it is my responsibility to be aware of the signs and symptoms of Vertebrobasilar Insufficiency (VBI). I am aware that having any, or a number, of the symptoms listed below are my individual and personal responsibility to ensure that I am fully aware of the documented precautions and contraindications to manipulative therapy techniques.
 - a. Dizziness/ vertigo/ giddiness/ lightheadedness
 - b. Drop attacks/ loss of consciousness; Diplopia
 - c. Dysarthria
 - d. Dysphagia
 - e. Ataxia of gait
 - f. Nausea; nystagmus
 - g. Numbness on one side of face and/or body
3. I understand It may be necessary to remove clothing to perform certain procedures, observation, and/or examination correctly.
4. I agree that it is my responsibility to inform the operator should I experience any pain, discomfort, or symptoms during any procedures. I acknowledge that it is the responsibility of the operator to stop the procedure immediately should I indicate pain, discomfort, or symptoms or request that the procedure be stopped.
5. I understand that transient side effects of neck manipulations are not uncommon and generally appear within 4 hours and disappear within 24 hours. Common transient side effects include headache, stiffness, local discomfort, radiating discomfort, and fatigue. Less common transient side effects include dizziness, nausea, and hot skin.
6. Should any untoward reaction or response or side effect develop, the procedure to be followed has been explained to me:
 - a. **Cessation of Practice:**
 - i. In the event of the development of any untoward reaction or side effect, either during or subsequent to the procedure, the procedure will be stopped and/or not repeated on that occasion. The patient must notify the operator when any untoward reaction or response or side effect occurs. With the mutual agreement of the patient and operator, such a procedure may be undertaken at a later date.

I have read the above and declare that I am willing and able to take part in High-Velocity Low-Amplitude Thrust Manipulation. I understand in the event of a physical injury or illness resulting from these techniques, no monetary compensation or free medical treatment will be provided. I understand that in the event of physical injury or illness resulting from these procedures, I should seek treatment from my own health care provider.

I agree that it is my responsibility to inform the operator of any changes in health status during my period of treatment after the completion of this consent form. I release Heinen Physical Therapy, PLLC and any affiliates from an and all liability, claims, or actions of any kind that may arise by or in connection with my participation in High-Velocity Low-Amplitude thrust manipulation.

Patient/Legal Guardian

Signature: _____ Date: _____

Printed Name: _____

Relationship, if signed other than by client: _____