

# Chiropractic Alchemy (BodyMind Alchemy, LLC)

## Informed consent to treatment for Chiropractic care

I hereby request and consent to receive spinal care, including wellness education, in this office by a chiropractor who provides Network Spinal Analysis (NSA), a low force approach which has unique outcomes and clinical results. This chiropractor chooses to practice NSA, as she is personally and professionally confident in regards to the safety and effectiveness of this form of care.

The purpose of this consent form is to better help me understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with the snapping and popping sound), nor does it directly treat painful areas of the spine and body. *Instead by enhancing my body's awareness of itself and specially the spine, I understand that I can develop new strategies for healing, adapting to stress and experiencing wellness. These strategies promote spontaneous self correction and self-regulation of spinal tension patterns and healing.*

NSA consists of gentle contacts along the neck and back to achieve greater communication between the brain and body, and new sensory motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research categorizing NSA care and documenting its unique and significant wellness benefits. I understand that I may receive copies of published research articles and/or abstracts in this office upon request.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension and ease patterns. At regular intervals re-assessments will be performed. These will include my personal perception of my wellness and awareness of my spine and mind-body changes. My chiropractor will report to me the improvements in my spine and nervous system integrity and my ability to re-organize my spine.

NSA is advanced through a series of levels of care. Each level of care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves which are suggested to be associated with greater spinal stability, re-distribution of energy, and transfer of internal information are also associated with greater wellness, improved quality of life and increased life enjoyment.

I also understand that in addition to NSA that my chiropractor may perform additional examinations or assessments and offer health/spinal care and advice that is consistent with my individual needs.

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## PLEASE READ AND SIGN THE FOLLOWING

It has been explained to my satisfaction, and I understand that the care offered in this office is not a form of, or replacement for, the diagnosis and treatment of any symptom, disease or malady. Instead it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity. It develops new capabilities in my body for the identification of, spontaneous release of, and redirection of tension, including those unique to NSA.

It is common for people in NSA care to breathe more deeply and fully, engaging the spine with their respiration, to spontaneously adopt postures that release or redistribute tension and to experience more of their inner life energy.

I understand that it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and life, which often lead to significant life changes. *This form of care is not suggested for those individuals who wish to remove a symptom or condition without the occurrence of a fundamental change in their lives.* The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion and consciousness.

Rather than attempting to simply return me to my previous state, minus my symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

I have read this consent form to receive Network Spinal Analysis care and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and my healing.

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

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

### **Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.