

**Action Chiropractic**  
**Neck pain, Back Pain**  
**& Headache Relief Center**  
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**PATIENT CONSENT TO X-RAY**

I authorize the performance of diagnostic x-ray examination of myself which Dr. \_\_\_\_\_ may consider necessary or advisable in the course of my examination and treatment.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONSENT TO X-RAY A MINOR**

I am the parent or legal representative of \_\_\_\_\_, who is a minor, \_\_\_\_\_ years of age. I authorize the performance of diagnostic x-ray of this child or ward which Dr. \_\_\_\_\_ may consider necessary or advisable in the course examination or treatment.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FEMALES: REGARDING POSSIBILITY OF PREGNANCY**

This is to certify that, to the best of my knowledge I am or may be pregnant and that Dr. \_\_\_\_\_ has my permission to perform diagnostic x-ray examination involving my cervical spine (neck) or extremities (arm, or legs), on the condition that lead shielding be utilized over the trunk of my body. I have been advised that certain x-ray examination's, particularly those involving the pelvis, can be hazardous to an unborn child.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_