

**CHIROPRACTIC WELLNESS CENTER OF BALTIMORE**

**X-RAY CONSENT FORM**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment.

By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS PORTION FOR WOMEN ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant.  Yes  No

I could be pregnant.  Yes  No

I am late with my menstrual period.  Yes  No

I am taking contraceptives.  Yes  No

I have had a tubal ligation.  Yes  No

I have had a hysterectomy.  Yes  No

I have irregular menstrual periods.  Yes  No

My last menstrual period began on \_\_\_\_\_

With full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

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

**THIS FORM IS FOR EVERYONE; PLEASE SEE TOP PORTION.**