Dr. Mizel
320 Vine Street
St. Catharines, Ontario L2M 4T3
TEL (905) 934-7776 FAX (905) 934-7778

# Informed Consent to Examination and X-ray

**I hereby request and consent to the performance of a Chiropractic, Physiotherapy, Massage Therapy, Orthopaedic and Neurological examination and diagnostic x-rays (if required) which will determine if Chiropractic, Physiotherapy, or Massage Therapy can help me. I understand that there is a very low risk of injury or aggravation from the examination procedures. These risks may include muscle strains and sprains, rib fractures, disc injuries, and strokes. Most important, tell us if you are pregnant or think you might be.**

**Dated this _____ day of _____, 2019.**

**_____** **_____**
**Patient Signature (Legal Guardian)** **Signature of Witness**

**Name:_____** **Name: _____**
**(Please Print)** **(Please Print)**

**FOR WOMEN ONLY:**
**Date of last period? _____** **Are you pregnant? ❑ Yes ❑ No ❑ Maybe**