



## PEDIATRIC INTAKE FORM

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ ☐ Male ☐ Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pediatrician/Family MD: \_\_\_\_\_ City & State: \_\_\_\_\_

Last Visit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for Visit: \_\_\_\_\_

Who is responsible for bills/finances? \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ Other (Please Explain) \_\_\_\_\_

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THE OFFICE					
Health Concern: (List according to Severity)	Rate of severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did this begin with an injury?	Are symptoms Constant (C) Intermittent (I)?
1st: _____	_____	_____	_____	_____	_____
2nd: _____	_____	_____	_____	_____	_____
3rd: _____	_____	_____	_____	_____	_____
4th: _____	_____	_____	_____	_____	_____

PURPOSE OF THIS VISIT: ☐ Wellness Check-Up ☐ Injury or Accident ☐ Other: \_\_\_\_\_

PLEASE EXPLAIN: \_\_\_\_\_

If your child is experiencing pain/discomfort, please identify where and for how long: \_\_\_\_\_

- When did this problem first begin? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Unknown ☐ Gradual ☐ Sudden
- Have you seen other doctors for these conditions? ☐ Yes ☐ No If yes, who & when? \_\_\_\_\_
- What were the results? ☐ FAVORABLE ☐ UNFAVORABLE (please explain) \_\_\_\_\_
- How is this problem NOW: ☐ Quickly Improving ☐ Slowly Improving ☐ Same ☐ Gradually Worsening ☐ On+Off
- Any bowel or bladder problems since this problem began?: ☐ Yes ☐ No  
If yes; please describe: \_\_\_\_\_
  - Ever experienced this problem before? ☐ Yes ☐ No  
If yes; when: \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years
- Please list any medication taken for this problem: \_\_\_\_\_
- Does your child participate in organized sports? ☐ Yes ☐ No If yes, Have they ever sustained an injury? Please explain: \_\_\_\_\_

Has your child ever been in an auto accident? ☐ Yes ☐ No If yes, Have they ever sustained an injury?

Please explain: \_\_\_\_\_

**Please Mark "P" For In The Past OR Mark "C" For Currently Have:**

<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Colic
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Migraines	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Reflux
<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fall from Bed or Couch
<input type="checkbox"/> Backaches	<input type="checkbox"/> Fainting	<input type="checkbox"/> Trouble Breathing	<input type="checkbox"/> Fall from Changing Table
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Rupture/Hernia	<input type="checkbox"/> Fall from Crib
<input type="checkbox"/> Leg Problems	<input type="checkbox"/> Sensory & Spectrum	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Fall from High Chair
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Fall in Baby Walker
<input type="checkbox"/> Foot Pain	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Fall off Bicycle
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Recurrent Colds/Flu	<input type="checkbox"/> Constipation	<input type="checkbox"/> Fall off Monkey Bars
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Allergies	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fall off Skateboard/Skates
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Fall off Slide
<input type="checkbox"/> Muscle Pains	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Fall Down Stairs
<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Chronic Earaches	<input type="checkbox"/> Anemia	<input type="checkbox"/> Fall off Swing
<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Walking Trouble

Other(s): \_\_\_\_\_

**Pregnancy Information:**

Overall, how was your pregnancy? \_\_\_\_\_

Any Pregnancy Complications? \_\_\_\_\_

Did you take any medication during your pregnancy? \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

**Delivery Information:**

Location of Birth: ☐ Hospital ☐ Birth Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Cesarean Section

Induced? ☐ Yes ☐ No Medications during delivery? \_\_\_\_\_

Other Information: \_\_\_\_\_

**Post Birth Information:**

Breast Fed: ☐ Yes ☐ No If yes, how long? \_\_\_\_\_ Introduced Solid Foods at \_\_\_\_\_ months

Food Allergies or Intolerances: \_\_\_\_\_

Doses of antibiotics/prescription drugs your child has taken: Past 6 Months \_\_\_\_\_ Total of Lifetime \_\_\_\_\_

Current prescription drugs/dosage? \_\_\_\_\_

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) \_\_\_\_\_

List all surgical operations and years: \_\_\_\_\_

Has your Child ever been knocked unconscious? ☐ Yes ☐ No Fractured A Bone? ☐ Yes ☐ No

If yes to either of the above, please describe:

\_\_\_\_\_

## Activities Of Life

Please identify how the current condition is affecting the child's ability to carry out activities that are routinely part of life:

<u><b>ACTIVITY:</b></u>	<u><b>EFFECT:</b></u>			
Holding Head Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Tummy Time	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Nursing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Crawling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Unassisted	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking Unassisted	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other:_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

### **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

\_\_\_\_\_  
GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

### **INFORMED CONSENT FOR CHIROPRACTIC CARE**

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

\_\_\_\_\_  
PRINT NAME OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

### **WRITTEN CONSENT FOR A CHILD**

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD \_\_\_\_\_

I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO CHASE LIFE CHIROPRACTIC FOR ALL FEES ASSOCIATED WITH CHIROPRACTIC CARE MY CHILD RECEIVES. I AUTHORIZE DR. CHASE BLAHA AND ANY AND ALL CHASE LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD. ALL RISKS OF CHIROPRACTIC CARE HAVE BEEN EXPLAINED TO ME I HAVE CONVEYED MY UNDERSTANDING OF THESE RISKS TO THE DOCTOR.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY CHASE LIFE CHIROPRACTIC. UNDER THE TERMS AND CONDITIONS OF MY DIVORCE, SEPARATION, OR OTHER LEGAL AUTHORIZATION, THE CONSENT OF A SPOUSE/FORMER SPOUSE OR OTHER GUARDIAN IS NOT REQUIRED. IF MY AUTHORITY TO SO SELECT AND AUTHORIZE THIS CARE SHOULD CHANGE IN ANY WAY, I WILL IMMEDIATELY NOTIFY CHASE LIFE CHIROPRACTIC.

\_\_\_\_\_  
PRINT NAME OF GUARDIAN

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DOCTOR/CA SIGNATURE

\_\_\_\_\_  
DATE

**Practice Member Information (Must be completed before services can be rendered)**

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: \_\_\_\_\_

CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**NAME OF PRIMARY INSURANCE CARRIER:** \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ INSURED DATE OF BIRTH: \_\_\_\_\_

INSURED SOCIAL SECURITY NUMBER: \_\_\_\_\_

**NAME OF SECONDARY INSURANCE CARRIER:** \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ INSURED DATE OF BIRTH: \_\_\_\_\_

INSURED SOCIAL SECURITY NUMBER: \_\_\_\_\_

**INSURANCE POLICIES AND FEE SCHEDULE**

- CONSULTATION: INCLUDES PRACTICE MEMBER HISTORY. THIS SERVICE IS COMPLIMENTARY
- ASSESSMENT (NEW OR ESTABLISHED PRACTICE MEMBER): INCLUDES ONE OR MORE OF THE FOLLOWING: THERMOGRAPHY, SURFACE ELECTROMYOGRAPHY, RANGE OF MOTION, MOTION AND/OR STATIC PALPATION, LEG CHECK \$50-\$75
- CHIROPRACTIC ADJUSTMENT: THE ACTUAL RE-ALIGNMENT OF THE VERTEBRA DONE BY HAND. OFTEN A SOUND WILL BE HEARD BUT IF THERE IS NO AUDITORY RESULT, IT DOES NOT MEAN THE ADJUSTMENT HAS NOT TAKEN PLACE. \$40-\$60
- XRAY: SPECIFIC XRAY VIEWS TAKEN OF YOUR SPINE TO BE DETERMINE A MISALIGNMENT/SUBLUXATION OF YOUR VERTEBRAE. THESE CAN ALSO BE USED TO INDICATE PROGRESS AFTER PERIOD OF CARE. \$50 PER VIEW

**RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS**

I AUTHORIZE AND REQUEST PAYMENT OF INSURANCE BENEFITS DIRECTLY TO CHASE BLAHA, DC. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL SERVICES RENDERED UNTIL I REVOKE THE AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THAT IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT AND THAT CHASE LIFE CHIROPRACTIC RESERVES THE RIGHT TO ADD A \$25.00 SERVICE CHARGE TO MY ACCOUNT FOR ANY RETURNED CHECK OR CHARGEBACK. I AUTHORIZE THE FACILITY ALONG WITH ANY BILLING SERVICE AND THEIR COLLECTION AGENCY OR ATTORNEY WHO MAY WORK ON THEIR BEHALF, TO CONTACT ME ON MY CELL PHONE AND/OR HOME PHONE USING PRE-RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRONIC MAIL, TEXT MESSAGING OR ANY OTHER FORM OF ELECTRONIC COMMUNICATION.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

## X-RAY AUTHORIZATION

Last, First, M: \_\_\_\_\_

FILE #: \_\_\_\_\_

DOB: \_\_\_\_\_

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS \$15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR DAY OF OPERATION.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS.

THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF CHASE LIFE CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT NAME HERE

DATE OF BIRTH

SIGNATURE

DATE

**FEMALE PATIENT ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT CHASE LIFE CHIROPRACTIC.

SIGNATURE

DATE \_\_\_\_\_

----- DO NOT WRITE BELOW THIS LINE -----

<input type="checkbox"/> Lat Cervical <input type="checkbox"/> Flex/Ext CM      Kvp      Time      MAS <input type="checkbox"/> 10-11 <input type="checkbox"/> 78 <input type="checkbox"/> 1/24    12.5 <input type="checkbox"/> 12-13 <input type="checkbox"/> <input type="checkbox"/> 1/20    15 <input type="checkbox"/> 14-15 <input type="checkbox"/> 1/15    20 <input type="checkbox"/> 16-17 <input type="checkbox"/> 1/10    30 <input type="checkbox"/> 2/15    40 MA 300      Size 8x10				<input type="checkbox"/> Lower Cervical CM      Kvp      Time      MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10    20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15    30 <input type="checkbox"/> 18-19 <input type="checkbox"/> 3/20    40 <input type="checkbox"/> 20-21 <input type="checkbox"/> 2/10    50 <input type="checkbox"/> 22-23 MA 300      Size 8x10				<input type="checkbox"/> Lateral Thoracic CM      Kvp      Time      MAS <input type="checkbox"/> 22-23 <input type="checkbox"/> 80 <input type="checkbox"/> 1/15    20 <input type="checkbox"/> 24-25 <input type="checkbox"/> <input type="checkbox"/> 1/10    30 <input type="checkbox"/> 26-27 <input type="checkbox"/> 2/15    40 <input type="checkbox"/> 28-29 <input type="checkbox"/> 2/10    50 <input type="checkbox"/> 30-31 <input type="checkbox"/> 1/4      75 <input type="checkbox"/> 32-33 <input type="checkbox"/> 3/10    90 <input type="checkbox"/> 34-35 <input type="checkbox"/> 2/5      120 <input type="checkbox"/> 36-37 <input type="checkbox"/> 1/2      150 MHA 300      Size 14x17				<input type="checkbox"/> A-P Thoracic CM      Kvp      Time      MAS <input type="checkbox"/> 16-17 <input type="checkbox"/> 75 <input type="checkbox"/> 1/20    17 <input type="checkbox"/> 18-19 <input type="checkbox"/> <input type="checkbox"/> 1/15    22 <input type="checkbox"/> 20-21 <input type="checkbox"/> 1/10    30 <input type="checkbox"/> 22-23 <input type="checkbox"/> 2/15    40 <input type="checkbox"/> 24-25 <input type="checkbox"/> 2/10    50 <input type="checkbox"/> 26-27 <input type="checkbox"/> 1/4      75 <input type="checkbox"/> 28-29 <input type="checkbox"/> 3/10    90 <input type="checkbox"/> 30-31 <input type="checkbox"/> 2/5      120 MA 300      Size 14x17			
<input type="checkbox"/> APOM CM      Kvp      Time      MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10    20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15    30 <input type="checkbox"/> 18-19 <input type="checkbox"/> 3/20    40 <input type="checkbox"/> 20-21 <input type="checkbox"/> 2/10    50 <input type="checkbox"/> 22-23 MA 300      Size 8x10				Other View _____  CM _____ Kvp _____  MAS _____ MA _____  Size _____				<input type="checkbox"/> Lateral Lumbar CM      Kvp      Time      MAS <input type="checkbox"/> 26-27 <input type="checkbox"/> 88 <input type="checkbox"/> 2/10    30 <input type="checkbox"/> 28-29 <input type="checkbox"/> 90 <input type="checkbox"/> 1/4      40 <input type="checkbox"/> 30-31 <input type="checkbox"/> 92 <input type="checkbox"/> 3/10    50 <input type="checkbox"/> 32-33 <input type="checkbox"/> 94 <input type="checkbox"/> 2/5      70 <input type="checkbox"/> 34-35 <input type="checkbox"/> 96 <input type="checkbox"/> 1/2      90 <input type="checkbox"/> 36-37 <input type="checkbox"/> <input type="checkbox"/> 3/5      120 <input type="checkbox"/> 38-39 <input type="checkbox"/> 4/5      160 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1        200 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 200      Size 14x17				<input type="checkbox"/> A-P Lumbar CM      Kvp      Time      MAS <input type="checkbox"/> 20-21 <input type="checkbox"/> 76 <input type="checkbox"/> 1/15    40 <input type="checkbox"/> 22-23 <input type="checkbox"/> 78 <input type="checkbox"/> 1/10    50 <input type="checkbox"/> 24-25 <input type="checkbox"/> 80 <input type="checkbox"/> 2/15    75 <input type="checkbox"/> 26-27 <input type="checkbox"/> <input type="checkbox"/> 2/10    90 <input type="checkbox"/> 28-29 <input type="checkbox"/> 1/4      120 <input type="checkbox"/> 30-31 <input type="checkbox"/> 3/10    150 <input type="checkbox"/> 32-33 <input type="checkbox"/> 2/5      120 <input type="checkbox"/> 34-35 <input type="checkbox"/> 1/2      170 <input type="checkbox"/> 36-37 <input type="checkbox"/> 3/5      210 <input type="checkbox"/> 38-39 <input type="checkbox"/> 4/5 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 300      Size 14x17			
Sex: M / F  NOTES: _____ _____ _____ _____ _____ _____				CA Initials: _____											