



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) _____

PURPOSE OF THIS VISIT: Wellness Check-Up Injury or Accident Other: _____

WHAT ARE THE PRIMARY HEALTH CONCERNS FOR YOUR CHILD? _____

1. When did this problem first begin? Date: ____/____/____ Unknown Gradual Sudden
2. Have you seen other doctors for these conditions? Yes No
 - a. If yes, please name them and their specialty and date seen: yes, who & when?

3. What were the results? FAVORABLE UNFAVORABLE (please explain)

4. How is this problem **NOW**:
 Quickly Improving Slowly Improving Same Gradually Worsening On+Off
5. What makes things **BETTER**? _____ **WORSE**? _____
6. Any bowel or bladder problems since this problem began?: Yes No
 If yes; please describe:

 - a. Ever experienced this problem before? Yes No
 - b. If yes; when: _____ Days _____ Weeks _____ Months _____ Years
7. Please list any medication, drugs, vitamins, herbs, other your child is taking: _____

8. Does your child participate in organized sports? Yes No
 - a. If yes, have they ever sustained an injury? Yes No
 - b. If yes, please explain:

9. Has your child ever been in an auto accident? Yes No
 - a. If yes, Have they ever sustained an injury? Yes No
 - b. If yes, please explain:

10. Are there any other health concerns, or is there anything else you'd like us to know about your child?

WHAT ARE YOUR TOP THREE HEALTH GOALS FOR YOUR CHILD:
 1. _____
 2. _____
 3. _____

PREGNANCY & FERTILITY HISTORY

Any Fertility Challenges? Yes No If yes, please explain _____
Did the mother smoke during pregnancy? Yes No If yes, how many per week? _____
Did the mother drink during pregnancy? Yes No If yes, how many per week? _____
Did the mother exercise during pregnancy? Yes No If yes, explain briefly _____
Was the mother ill during pregnancy? Yes No If yes, please explain _____
Any Ultrasounds taken during pregnancy? Yes No If yes, please explain _____
Please explain any notable episodes of emotional or physical stress during your pregnancy: _____

Please explain any other concerns or notable remarks about your child's conception or pregnancy: _____

LABOR & DELIVERY HISTORY

Child's birth was: Vaginal Birth Scheduled C-Section Emergency C-Section
How many weeks was your child born? _____
Child's birth was: at home at a hospital at a birthing center Other _____
Please check any applicable interventions or complications:
 Breech Induction Pain meds Manual Assistance Epidural Episiotomy
 Vacuum extraction Forceps Cord-wrapped None of the above

Please describe any other concerns or notable remarks about your child's labor and/or delivery? _____

POST BIRTH INFORMATION

Is / was your child breastfed? Yes No If yes, how long? _____
Difficulty breastfeeding? Yes No If yes, is a certain side more difficult than other? _____
Did they ever use formula? Yes No If yes, at what age? _____
Did / does your child suffer from colic, reflux, jaundice, skin issues or constipation as an infant? Yes No
If yes, please explain? _____

Did / does your child frequently arch their neck / back, feel stiff or bang their head? Yes No
If yes, please explain? _____

GROWTH AND DEVELOPMENT

Introduced Solid Foods at _____ months
How would you describe your child's diet? whole, organic foods pretty average mainly processed foods
Food Allergies or Intolerances: _____
Doses of antibiotics/prescription drugs your child has taken: Past 6 Months _____ Total of Lifetime _____
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: _____
Have you chosen to vaccinate your child? Yes, on schedule Yes, on delayed or selective schedule No
If yes, please list any vaccination reactions: _____

Behavioral, social or emotional issues? Yes No If yes, please explain? _____
How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____
What age did your child crawl? _____ Did your child: Army Crawl Butt Scoot Cross Crawl
other crawling patterns: _____

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"/> Mouth Breathing	<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"/> Breathing Problems	<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"/> Projectile Vomiting	<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"/> W Sitting	<input type="checkbox"/> Allergies	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fall off Skateboard/Skates
<input type="checkbox"/> Excessive spit up	<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"/> Torticollis	<input type="checkbox"/> Fall Down Stairs
<input type="checkbox"/> Connective Tissue Disorder	<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
<input type="checkbox"/> Plagiocephaly	<input type="checkbox"/> Communication Delays	<input type="checkbox"/> Emotional Challenges	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Motor Milestone Delays	<input type="checkbox"/> Low energy/Fatigue	<input type="checkbox"/> Sore throat / strep	<input type="checkbox"/> Swollen tonsils/adenoids
<input type="checkbox"/> Chronic Inflammation	<input type="checkbox"/> Poor metabolism	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Blood Sugar Problems
<input type="checkbox"/> Hormonal Challenges	<input type="checkbox"/> Toe Walking	<input type="checkbox"/> Gluten Intolerance	<input type="checkbox"/> Kidney Challenges
<input type="checkbox"/> Hip Dysplasia	<input type="checkbox"/> Labored Breathing	<input type="checkbox"/> Sprengel's Deformity	<input type="checkbox"/> Bloating

Other(s): _____

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:

ACTIVITY:

EFFECT:

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
- XRAYS: 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: _____

MEDIA RELEASE AGREEMENT

I grant permission to Chase Life Chiropractic hereinafter known as the "Media" to use my child's image (photographs and/or videos) for use in Media publications including: Social Media Posts, Videos, Email Blasts, Education Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

I hereby waive any right to approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image(s).

Please initial the paragraph below:

_____ I am the parent or guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

PRINT NAME (your name or minor child name)

DATE

SIGNATURE

SIGNATURE OF LEGAL GUARDIAN (if under 18 years of age)

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 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"/> Flex/Ext 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"/> 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: _____							