



2 Park of Commerce Blvd.

Suite D

Savannah, GA 31405

912.777.3717

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Male Female

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

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Cell Phone Provider \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer's Name \_\_\_\_\_ Position \_\_\_\_\_

Single Married Divorced Widowed Spouse's Name \_\_\_\_\_

Number of Children \_\_\_\_\_ Names, Ages & Gender \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

### **LIST YOUR HEALTH CONCERNS BELOW**

<b>Health Concerns:</b> List according to severity	Rate of Severity 1=mild 10 =unbearable	When did this episode start?	If you had the condition before, when?	Did the Problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS?

YES NO

CHIROPRACTOR? \_\_\_\_\_ MEDICAL DOCTOR? \_\_\_\_\_ OTHER \_\_\_\_\_

WHO AND WHEN? \_\_\_\_\_

### **✓ CHECK ALL CURRENT PROBLEMS YOU HAVE**

ADD/ADHD	CHEST PAIN	HEADACHES	LIVER DISEASE	NUMBNESS IN FEET
ALLERGIES	CHRONIC FATIGUE	HEART PROBLEMS	LOW BACK PAIN	NUMBNESS IN HAND
ANXIETY	COLIC	HYPERTENSION	LUPUS	NUMBNESS IN LEGS
ARM PAIN	DEPRESSION	HIP PAIN	MENSTRUAL ISSUES	PREGNANCY
ARTHRITIS	DIZZINESS	IMMUNE DEFICIENT	MID BACK PAIN	SCIATICA
AUTISM	DISC PROBLEM	INFERTILITY	MIGRAINES	SHOULDER PAIN
AUTO IMMUNE	EAR INFECTIONS	IRRITABLE BOWEL	NAUSEA	SINUS INFECTIONS
BLADDER PROBLEMS	EPILEPSY	KIDNEY PROBLEMS	NECK PAIN	STOMACH ISSUES
CANCER	FIBROMYALGIA	KNEE PAIN	NERVOUSNESS	THYROID PROBLEMS
OTHER _____	GASTRIC REFLUX	LEG PAIN	NUMBNESS IN ARMS	VERTIGO

✓ **CHECK ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD IN THE PAST**

STROKE

HEART DISEASE

SPINAL SURGERY

SEIZURES

SPINAL FRACTURE

SCOLIOSIS

DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS \_\_\_\_\_

LIST ALL over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON \_\_\_\_\_

WHEN WAS YOUR LAST AUTO ACCIDENT \_\_\_\_\_

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YES, DR AND DATE \_\_\_\_\_

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES, PLEASE DESCRIBE \_\_\_\_\_

OTHER TRAUMA \_\_\_\_\_

**SOCIAL HISTORY**

1. **SMOKING:** \_\_\_cigars \_\_\_pipe \_\_\_cigarettes → How often? \_\_\_Daily \_\_\_Weekends \_\_\_Occasionally \_\_\_Never

2. **EXERCISE:** How often? \_\_\_Daily \_\_\_Weekends \_\_\_Occasionally \_\_\_Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE**

**4. CHECK ANY ACTIVITIES OF DAILY LIVING ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:**

Bathing/Showering

Toilet Hygiene

Personal Hygiene

Self Feeding

Walking

Dressing

**\*PLEASE MARK** the areas on the diagram with the following letters

to describe your symptoms:

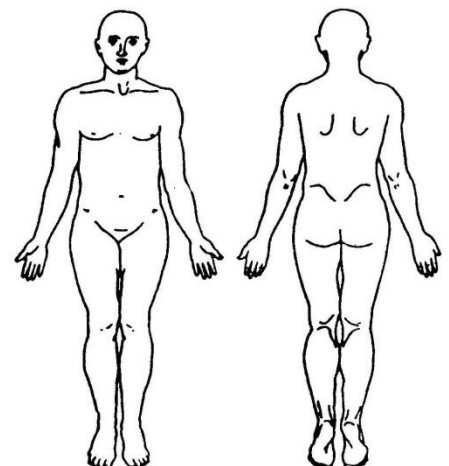
R=Radiating D=Dull N= Numbness

B=Burning A=Aching

S= Sharp/Stabbing

What relieves your symptoms? \_\_\_\_\_

What makes them worse? \_\_\_\_\_



# QUADRUPLE VISUAL ANALOGUE SCALE

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

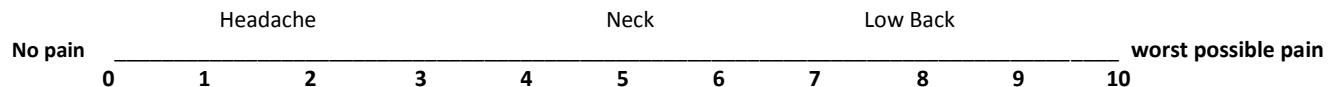
Date \_\_\_\_\_

## Please read carefully:

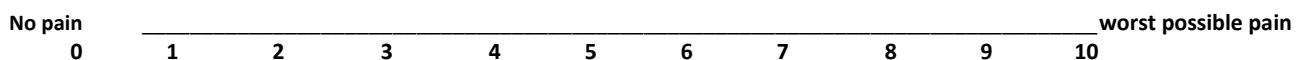
**Instructions:** Please check the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

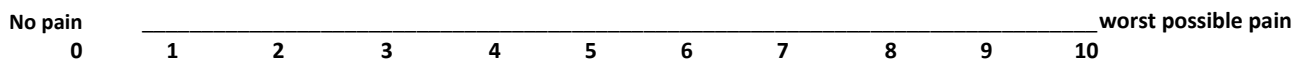
### Example:



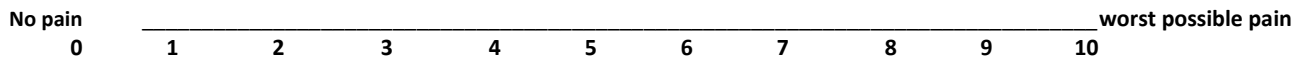
1 – What is your pain RIGHT NOW?



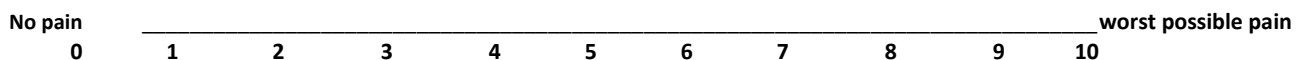
2– What is your TYPICAL or AVERAGE pain?



3– What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4– What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



### OTHER COMMENTS:

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Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## Activities of Life

Based on the "EFFECT SCALE" from the previous page, rate how each activity affects you.  
Place an "✓" in the box to mark your rating. Use "N/A" for any activity Not Applicable to you (or your child).

### PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Bathing / Showering					
Grooming Hair					
Brushing Teeth					
Using The Toilet					
Dressing The Upper Body					
Dressing The Lower Body					

### DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Standing					
Sitting					
Squatting					
Kneeling					
Reaching Overhead					
Bending Forward					
Turning Left					
Turning Right					
Move From Lying to Sitting					
Move From Sitting to Standing					
Move From Standing to Sitting					

### FUNCTIONAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Sleeping					
Eating					
Going Up & Down Stairs					
Getting In & Out of Car					
Driving					
Using A Computer					
Focusing / Concentrating					
Preparing Food					
Household Chores					
Lifting Children					
Carrying Bag / Purse					

### SOCIAL, RECREATIONAL & OTHER ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	No effect	Painful (can do)	Painful (limits)	Unable to perform.	
Competitive Sports					
Running / Jogging / Hiking					
Other Recreation Activities					
Hobbies					
Sexual Activity					

## PRACTICE MEMBER INFORMATION

**\*\*\*MUST BE COMPLETED IN FULL BEFORE SERVICES CAN BE RENDERED\*\*\***

NAME: \_\_\_\_\_  
First Middle Last

PHONE: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

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

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 new practice member history. This service is complementary.
- **Specific, Scientific Chiropractic 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.
- **Specific, Scientific Chiropractic Adjustment:** The actual re-alignment of the misaligned vertebra. Occasionally, a sound may be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$35-\$60.
- **Chiropractic Postural X-rays:** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. \$60 per view.

### Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jared Brown, D.C. or Samantha Brown, D.C. 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. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

## **TERMS OF ACCEPTANCE**

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
- G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **Notice of Privacy Practices Acknowledgement**

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

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

I acknowledge that I may request our 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 health care operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

\_\_\_\_\_  
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 SECONDARILY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/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 (NECK) 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 IS 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.

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

\_\_\_\_\_  
**PRINT PRACTICE MEMBER NAME**

\_\_\_\_\_  
**PRACTICE MEMBER'S SIGNATURE**

\_\_\_\_\_  
**DATE**

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**IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW**

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

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

**I AUTHORIZE DR. JARED BROWN AND/OR DR.SAMANTHA BROWN AND ANY AND ALL BRIGHT LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.**

**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 BRIGHT LIFE CHIROPRACTIC.**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR CHILD**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**BRIGHT LIFE CHIROPRACTIC WITNESS SIGNATURE**

**Medical Information Release Form  
(HIPAA Release Form)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release of Information:**

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse \_\_\_\_\_

☐ Child(ren) \_\_\_\_\_

☐ Other \_\_\_\_\_

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages:**

Please call ☐ my home ☐ my work ☐ my mobile number: \_\_\_\_\_

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ \_\_\_\_\_

The best time to reach me is (*day*) \_\_\_\_\_ between (*time*) \_\_\_\_\_

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

Bright Life Chiropractic representative: \_\_\_\_\_ Date: \_\_\_\_\_



# FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

\_\_\_\_\_  
PLEASE PRINT YOUR NAME HERE

\_\_\_\_\_  
DATE

**\*\*\*PLEASE PLACE AN "X" IN THE APPROPRIATE BOXES BELOW\*\*\***

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADHD					
ALLERGIES					
BACK TROUBLE					
BEDWETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECKPAIN					
SCOLIOSIS					
SINUS TROUBLE					
SURGERIES					
TMJ					

# X-RAY AUTHORIZATION

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

AT YOUR REQUEST, WE WILL PROVIDE 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 PRACTICE HOURS DAY. **PLEASE NOTE:** X RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE XRAYs ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF BRIGHT LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THATYOU CAN SEEK PROPER MEDICAL ADVICE.

PRINT YOUR NAME HERE

DATE

SIGNATURE

Date of Birth

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

SIGNATURE

DATE

Sex: ☐ Male ☐ Female

<b><input type="checkbox"/> LatCervical</b> 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 MA300 Size8x10	<b><input type="checkbox"/> Flex/Ext</b> 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 MA300 Size8x10	<b><input type="checkbox"/> LowerCervical</b> 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 MA300 Size8x10	<b><input type="checkbox"/> A-PThoracic</b> 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 <input type="checkbox"/> 31-32 <input type="checkbox"/> <input type="checkbox"/> MA300 Size14x17	<b><input type="checkbox"/> LateralThoracic</b> 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 <input type="checkbox"/> 38-39 <input type="checkbox"/> <input type="checkbox"/> MA300 Size14x17	
<b><input type="checkbox"/> APOM</b> 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 MA300 Size8x10	<b><input type="checkbox"/> Other</b> View _____ CM _____ Kvp _____ MAS _____ MA _____ Size _____	<b><input type="checkbox"/> A-PLumbar</b> 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			<b><input type="checkbox"/> LateralLumbar</b> 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 75 <input type="checkbox"/> 34-35 <input type="checkbox"/> 96 <input type="checkbox"/> 1/2 90 <input type="checkbox"/> 36-37 <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 MA300 Size14x17

Notes:

Report of Findings is scheduled for:

CA Initials: