WELCOME TO

BRIGHT life
CHIROPRACTIC

Your First Day Journey:
(60 minutes)

o Complete New Patient Paperwork: Start your wellness adventure by filling out essential paperwork. Your health story begins here! (15 minutes)

o Front Desk Drop-off: Bring your completed paperwork to our friendly front desk team. They're here to assist and ensure a smooth check-in process.

o Educational Office Tour: Explore the heart of our practice! Our team will guide you through an educational tour, introducing you to our state-of-the-art facilities and wellness-focused atmosphere. (5 minutes)

o Thorough Consultation: Sit down with our chiropractic experts for a comprehensive consultation. Share your health goals, concerns, and let's pave the way to your best self! (10 minutes)

o Orthopedic and Neurological Exams: Experience a series of thorough exams designed to assess your musculoskeletal and neurological well-being. Your health puzzle is coming together! (10 minutes)

o Review of Neurological Exam: Gain insights into your neurological health. Our team will discuss the findings, providing clarity on your current status and potential areas for improvement. (10 minutes)

o On-Site X-rays: Dive deeper into your spine's story with on-site X-rays. These images help us tailor a precise and effective care plan crafted just for you. (10 minutes)

Your first day at Bright Life Chiropractic sets the stage for a wellness journey filled with positive transformations. Get ready to embark on a path toward vibrant health and well-being!

Any Questions?_____

_____

_____

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

Name _____ Date _____/_____/_____

Address_____

City_____ State_____ ZIP_____

Phone #_____ Email_____

Date of Birth_____/_____/_____ Age_____ Gender: MALE FEMALE

Employer's Name_____ Position_____

Marital Status: 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

HEALTH CONCERNS: *List according to severity*	Rate of Severity 1=mild 10=unbearable	Pain Description: R= Radiating D=Dull N=Numbness B=Burning A= Aching S=Sharp	When did this episode start?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1_____	_____	_____	_____	Y or N	C or I
2_____	_____	_____	_____	Y or N	C or I
3_____	_____	_____	_____	Y or N	C or I
4_____	_____	_____	_____	Y or N	C or I
5_____	_____	_____	_____	Y or N	C or I

Have you ever seen other doctors for these concerns? YES NO
If yes, Who and When?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

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

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

NAME:_____

HEALTH HISTORY

CIRCLE ANY CONDITIONS THAT YOU HAVE NOW OF 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 FRACTURE A BONE? YES NO

IF YOU, PLEASE DESCIBRE_____

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 you present problem affect the following: **HOBBIES, RECREATIONAL ACTIVITIES, EXERCISE**

_____

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

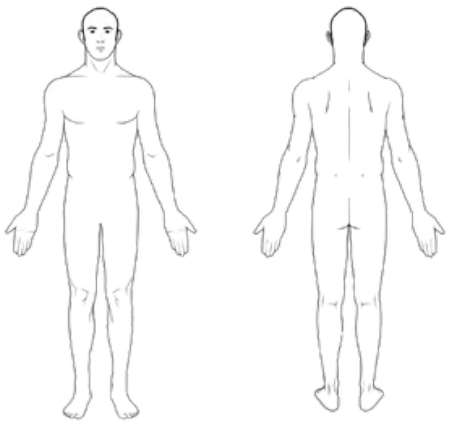
☐ **Bathing/Showering** ☐ **Personal Hygiene** ☐ **Walking**

☐ **Toilet Hygiene** ☐ **Self Feeding** ☐ **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?*_____

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

NAME:_____

Are there Health conditions you are afraid this might turn into?

- ◯ Family health problems
- ◯ Heart disease
- ◯ Cancer
- ◯ Diabetes
- ◯ Arthritis
- ◯ Fibromyalgia
- ◯ Depression
- ◯ Chronic fatigue
- ◯ Need surgery

What are you afraid your health condition could/is affecting?

- ◯ Job
- ◯ Kids
- ◯ Spouse
- ◯ Self Esteem
- ◯ Motivation
- ◯ Sleep
- ◯ Social Life
- ◯ Finances
- ◯ Freedom

How has your health affected you?

1. _____
2. _____
3. _____

What are you most concerned with regarding your problem?

_____

_____

Where do you picture yourself in the next 1-3 years if this problem is not taken care of?

_____

_____

What do you desire most to get from working with us?

_____

_____

What would that mean to you?

_____

_____

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

NAME:_____

ACTIVITIES OF LIFE

Place a check mark 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 PREFORM	
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 PREFORM	
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	☐	☐	☐	☐	

FUCTIONAL ACTIVITIES

ACTIVITY	RATING				ADDITIONAL NOTES:
	NO EFFECT	PAINFUL (CAN DO)	PAINFUL (LIMITS)	UNABLE TO PREFORM	
SLEEPING	☐	☐	☐	☐	
EATING	☐	☐	☐	☐	
GOING UP & DOWN STAIRS	☐	☐	☐	☐	
GETTING IN & OUT 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 PREFORM	
COMPETITIVE SPORTS	☐	☐	☐	☐	
RUNNING JOGGING/ HIKING	☐	☐	☐	☐	
OTHER RECREATION ACTIVITES	☐	☐	☐	☐	
HOBBIES	☐	☐	☐	☐	

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Please read carefully:

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

Note: If you have more that 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:

Headache Neck Low Back

No pain — Worst possible pain

0 1 (2) 3 4 (5) 6 7 8 (9) 10

1. **What is your pain RIGHT NOW?**

No pain — Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

2. **What is your TYPICAL or AVERAGE pain?**

No pain — Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

3. **What is your pain AT ITS BEST?**

No pain — Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

4. **What is your pain level AT ITS WORST?**

No pain — Worst possible pain

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Other Comments:

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

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. $40-$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**_____

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

Patient Name: _____ 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

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

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 OCCURING 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.

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**

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 CHIRORPACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIRORPACTIC 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 IMMEDIATLEY 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					

PRACTICE MEMBER PAPERWORK

BRIGHT life CHIROPRACTIC

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 _____ **YOUR DOB** _____

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**

☐ **LatCervical** ☐ **Flex/Ext**

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA300 Size8x10

☐ **LowerCervical**

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA300 Size8x10

☐ **APOM**

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA300 Size8x10

Other

View _____

CM ___ Kvp ____

MAS ___ MA ___-__

Size _____

☐ **A-PThoracic**

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120
☐31-32		☐	

MA300 Size14x17

☐ **A-PLumbar**

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1½	
		☐2	

☐ **LateralThoracic**

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150
☐38-39		☐	

MA300 Size14x17

☐ **LateralLumbar**

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	75
☐34-35	☐96	☐1/2	90
☐36-37		☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1½	
		☐2	

MA300 Size14x17

Notes:

Start Time:_____ **End Time:**_____

ADJ After? YES NO

CA Initials:

_____