**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 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:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | 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 level AT ITS BEST (How close to “0” does your pain get 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 (How close to “10” does your pain get at its worst)?** | | | | | | | | | |  |
| **No pain** | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | **worst possible pain** |
| **0** | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |



**OTHER COMMENTS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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.

**Practice Member Information (Must be Completed Before Services Can Be Rendered)**

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

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

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITIAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_

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

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 and chiropractic education. 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-$250.
* **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand or chiropractic instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
* **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 period of care. $40 per view.

**Release of Authorization/Assignment of Benefits**

I authorize and request payment of insurance benefits directly to Patrice Thompson, 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. 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 for 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 facility:

1. 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.
2. 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.
3. 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 doctors of chiropractic in the United States alone.
4. 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.
5. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
7. We invite you to speak frankly to the doctor on any matter related to your 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)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Witness 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: 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.

**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’S NAME HERE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. PATRICE THOMPSON AND ANY AND ALL COVINGTON FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES AND RADIOGRAPHIC EVALUATIONS TO MY MINOR/CHILD. I HEREBY AUTHORIZE DR. PATRICE THOMPSON TO 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 TOUCH OF LIFE FAMILY CHIROPRACTIC.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS SIGNATURE GUARDIAN’S RELATIONSHIP TO MINOR / CHILD

**FAMILY HEALTH HISTORY**

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION

FOR THEIR REVIEW.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE PLEASE PRINT YOUR NAME HERE

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CONDITION | SPOUSE | SON | DAUGHTER | MOTHER | FATHER |
| ARM PAIN |  |  |  |  |  |
| ARTHRITIS |  |  |  |  |  |
| ASTHMA |  |  |  |  |  |
| ADD/ADHD |  |  |  |  |  |
| ALLERGIES |  |  |  |  |  |
| BACK TROUBLE |  |  |  |  |  |
| BED WETTING |  |  |  |  |  |
| CANCER |  |  |  |  |  |
| CARPAL TUNNEL |  |  |  |  |  |
| DECEASED |  |  |  |  |  |
| DIABETES |  |  |  |  |  |
| DIGESTIVE PROBLEMS |  |  |  |  |  |
| DISC PROBLEMS |  |  |  |  |  |
| EAR INFECTIONS |  |  |  |  |  |
| FIBROMYALGIA |  |  |  |  |  |
| HEADACHES |  |  |  |  |  |
| HEARTBURN |  |  |  |  |  |
| HIGH BLOOD PRESSURE |  |  |  |  |  |
| HIP PAIN |  |  |  |  |  |
| LEG PAIN |  |  |  |  |  |
| MENSTRUAL DISORDER |  |  |  |  |  |
| MIGRAINES |  |  |  |  |  |
| NECK PAIN |  |  |  |  |  |
| SCOLIOSIS |  |  |  |  |  |
| SHOULDER PAIN |  |  |  |  |  |
| SINUS TROUBLE |  |  |  |  |  |
| TMJ |  |  |  |  |  |

**X-RAY AUTHORIZATION**

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.

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

**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 TOUCH OF LIFE FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT YOUR NAME HERE DATE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE YOUR AGE**

**FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT**

AT THE TIME X-RAYS ARE TAKEN AT TOUCH OF LIFE FAMILY CHIROPRACTIC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE DATE**

**DO NOT WRITE BELOW THIS LINE**  **DO NOT WRITE BELOW THIS LINE**  **DO NOT WRITE BELOW THIS LINE**

Sex: ☐ M ☐ F

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Lat Cervical ☐ 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  MA 300 Size 8x10 | ☐ Lower Cervical  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  MA 300 Size 8x10 | ☐ Lateral Thoracic  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  MA 300 Size14x17 | ☐ A-P Thoracic  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  MA 300 Size14x17 |
| ☐ 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  MA 300 Size 8x10 | Other  View \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CM\_\_\_\_\_\_\_\_\_ Kvp \_\_\_\_\_\_\_\_  MAS\_\_\_\_\_\_\_\_ MA\_\_\_\_\_\_\_\_  Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Lateral Lumbar  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 70  ☐34-35 ☐96 ☐1/2 90  ☐36-37 ☐ ☐3/5 120  ☐38-39 ☐4/5 160  ☐40-41 ☐1 200  ☐42-43 ☐1 1/2  ☐2  MA 200 Size 14x17 | ☐ A-P Lumbar  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 ☐1 1/2  ☐2  MA 300 Size 14x17 |
| Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **CA Initials: \_\_\_\_\_\_\_\_\_\_\_** |