VITAL LIFE
CHIROPRACTIC

Date ______/______/______

CHILDREN'S HEALTH PROFILE

Name of Child ____________________________________ Age__________ Date of birth ______/______/______

Gender – please circle one: Male Female Height ______________ Weight ____________________

Home address _______________________________ City ____________________ State _______ Zip _______________

PARENT/GUARDIAN A	PARENT/GUARDIAN B
Name ____	Name ____
Home phone __________________________________	Home phone ____________________________________
Cell phone ____________________________________	Cell phone ______________________________________
Employer _____________________________________	Employer _______________________________________
Email ____	Email ____

Name(s) and Age(s) of your child's sibling(s): ____

Select which is true for your child: ☐ Self Pay ☐ Insured (If insured, driver's license and insurance card copy needed)

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Mahan Family Chiropractic can address for your child? ______________________________

____

Related to: Sports Auto Fall Chronic Home Injury Other: ____________________________

Please describe how these concerns are affecting your child's quality of life. __________________________________

____

Circle any being affected:

- ☐ School
- ☐ Playing
- ☐ Communication
- ☐ Exercise/sports
- ☐ Sleep
- ☐ Eating
- ☐ Walking
- ☐ Attention/focus
- ☐ Daily routine

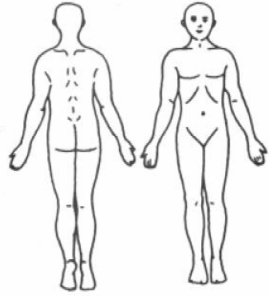
EXPECTATIONS OF CARE

I would like my child to experience the following benefits from chiropractic care:

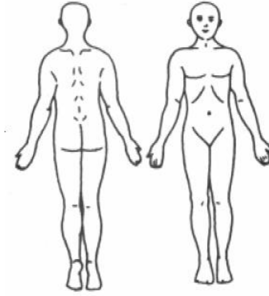
Check all that apply:

- ☐ Symptomatic relief of pain or discomfort
- ☐ Correction of the cause of the problem as well as relief of symptoms
- ☐ Prevention of future problems
- ☐ Healthier spine and nerve system
- ☐ Optimal health on all levels
- ☐ Other ____

#1 COMPLAINT



What is your main health concern for your child: ____
Is it: ☐Job Related ☐Auto Accident ☐Fall ☐Home Injury ☐Other: _______
When did this condition begin? ☐___Days ☐___Weeks ☐___Months ☐___Years
Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Burning
☐Tender ☐Stiff ☐Numb ☐Tingling ☐Excruciating
When do they experience their symptoms: ☐Morning ☐Afternoon ☐Night ☐Constant
☐Comes & Goes During the Day ☐Increased During the Day ☐Decreases During the Day ☐During Sleep
On a scale of 1 (minimal) – 10 (extreme): Please rate their pain RIGHT NOW: ____ AT ITS WORST: _____
What activities aggravate their condition? ____
What activities lessen their condition? ____
Does their pain travel to another location? Y / N If Yes, Where? _______________________________________
Is this condition interfering with: ☐Sleep? ☐Routine? ☐Other: ____________________________________
Have you seen other doctors for this concern? Y / N What did they recommend: __________________
Have they had previous chiropractic care? Y / N If yes, when? ______ Reason for initial visit? ___________
How long did they receive care? ___________________________ How often did they go? ________________
Additional information you feel your Doctors should know: ____
____
____
____



#2 COMPLAINT (If you do not have a 2nd complaint, please check here ☐ and skip to next section)
What is your main health concern for your child: ____
Is it: ☐Job Related ☐Auto Accident ☐Fall ☐Home Injury ☐Other: _______
When did this condition begin? ☐___Days ☐___Weeks ☐___Months ☐___Years
Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Burning
☐Tender ☐Stiff ☐Numb ☐Tingling ☐Excruciating
When do they experience their symptoms: ☐Morning ☐Afternoon ☐Night ☐Constant
☐Comes & Goes During the Day ☐Increased During the Day ☐Decreases During the Day ☐During Sleep
On a scale of 1 (minimal) – 10 (extreme): Please rate their pain RIGHT NOW: ____ AT ITS WORST: _____
What activities aggravate their condition? ____
What activities lessen their condition? ____
Does their pain travel to another location? Y / N If Yes, Where? _______________________________________
Is this condition interfering with: ☐Sleep? ☐Routine? ☐Other: ____________________________________
Have you seen other doctors for this concern? Y / N What did they recommend: __________________
Have they had previous chiropractic care? Y / N If yes, when? ______ Reason for initial visit? ___________
How long did they receive care? ___________________________ How often did they go? ________________
Additional information you feel your Doctors should know: ____
____
____
____

PREGNANCY & BIRTH

During pregnancy, did the mother:
Experience any significant illnesses, difficulties, or trauma? ____
Take any drugs/medications? ____
Smoke or consume alcohol? ____

HOME BIRTH HOSPITAL BIRTH VAGINAL WATER BIRTH CAESAREAN EMERGENCY-C

Child's Birth Weight: _______lbs. _______ oz. Birth Height: _______ft. _______ in. APGAR SCORE _____________

Was the delivery premature? NO YES WEEKS______________________________ WEIGHT___________________

Approximately, how long did labor last? ____ HOURS Was labor artificially induced? NO YES ________________

Was it determined that the child was breech or other malpositioned? NO YES ________________________

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

- □ **EPIDURAL**
- □ **PITOCIN**
- □ **FORCEPS**
- □ **EPISIOTOMY**
- □ **VACUUM**
- □ **MANUAL TRACTION OF THE NECK**
- □ **MEDICATIONS _____________ _____________**

Please check all that apply to the baby's state immediately after birth:

- □ **JAUNDICE**
- □ **FEEDING PROBLEMS**
- □ **RESPIRATORY PROBLEMS**
- □ **DISPLACED JOINTS**
- □ **BROKEN BONES**
- □ **OTHER CONDITIONS**

Was the baby breastfed? YES - FOR HOW LONG? ______ NO - WAS THIS DUE TO A COMPLICATION? __________

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes in contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? NO YES ☐ Delayed Schedule ☐ On Schedule
If yes, please check all vaccinations the child has received and at what age they were administered:

- □ **DPT ________**
- □ **POLIO ________**
- □ **HEPATITIS ________**
- □ **MMR ________**
- □ **CHICKEN POX ________**
- □ **FLU ________**
- □ **OTHER _______**

Please describe any and all reactions to vaccine(s) ____
Please check all that apply and give any necessary details

- □ **Child exposed to second hand smoke ____**
- □ **Has taken antibiotics. Explain ____**
- □ **Currently taking medication. Explain ____**
- □ **Currently taking supplements. Explain ____**
- □ **Has allergies. Explain ____**

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

- ◻ **Uncoordinated/Accident prone** ____
- ◻ **Has been hospitalized** ____
- ◻ **Had a severe trauma** ____
- ◻ **Been in an automobile accident** ____
- ◻ **Has fractured a bone or dislocate a joint** ____
- ◻ **Has/had a chronic illness** ____
- ◻ **Has had surgery** ____

What physical activated does your child participate in? ____

EMOTIONAL STRESS **If child is under 3, please check N/A ☐**

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

- ◻ **Academic pressure**
- ◻ **Lifestyle change**
- ◻ **Loss of a loved one**
- ◻ **Parents' divorce**
- ◻ **Bullying**
- ◻ **Loss of a pet**
- ◻ **Relocation**
- ◻ **New sibling**

Does your child have difficulty interacting with schoolmates or friends? YES NO

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? YES NO

HEALTH CARE PRACTITONER HISTORY

Has your child ever received chiropractic care? NO YES Name of D.C. ______________________________________

Reason ______________________________________ **How long?** __________________ **Date of last visit** _______________

Have you consulted or do you regularly consult any of the following providers for your child?
Please check all that apply

	Reason
◻ Medical Physician	______________________________________
◻ Massage Therapist	______________________________________
◻ Naturopath	______________________________________
◻ Psychotherapist	______________________________________
◻ Acupuncturist	______________________________________
◻ Energy Healer	______________________________________
◻ Homeopath	______________________________________
◻ Other	

FAMILY HEALTH HISTORY

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

Please Print Your Child's Name Here ____ Date __________________

CONDITION	CHILD	FATHER	MOTHER	SIBLING(S)
Acid Reflux/Heartburn/GERD				
ADD / ADHD				
Allergies				
Anxiety				
Arthritis / Joint Pain				
Asthma				
Autoimmune Problems				
Bed Wetting				
Birth Defect				
Cancer				
Colic				
Convulsions / Epilepsy				
Depression				
Diabetes				
Digestive Problems (Constipation/Diarrhea)				
Disc Problems				
Ear Problems/Hearing Loss				
Fatigue				
Fibromyalgia				
Frequent Cold / Flu				
Gall Bladder Problems				
Headaches / Migraines				
Heart Problems				
High / Low Blood Pressure				
HIV / AIDS				
Impotence/Sexual Dysfunction				
Kidney Problems				
Learning Disability				
Liver Problems				
Menstrual Dysfunction				
Mood Changes/Irritable				
Neck Pain / Back Pain				
Prostate Problems				
Sciatica				
Scoliosis				
Sinus / Drainage Problems				
Skin Problems				
Sleep Problems				
Thyroid Problems				
Tremors				
Vertigo / Dizziness				
Vision Problems				
Other:				

DEVELOPMENTAL MILESTONES

GROSS MOTOR SKILLS

- ❑ 4 wks Able to hold head up from the table momentarily
- ❑ 3 mths Head and shoulder can be supported by forearms
- ❑ 4 mths Infant can be pulled up into sit position by the hands
- ❑ 6 mths Sits unsupported in the upright position
- ❑ 6 mths Head and shoulders can be supported by the arms
- ❑ 6 mths Rolls from a face down to a face up position
- ❑ 9 mths Crawls
- ❑ 9 mths Stands holding onto furniture
- ❑ 11 mths Walks with someone holding onto one hand
- ❑ 12 mths Walks unassisted
- ❑ 2 years Runs
- ❑ 2 years Negotiates stairs placing 2 feet on each step
- ❑ 3 years Climbs stairs using one foot on each step
- ❑ 4 years Walks downstairs with one foot on each step
- ❑ 4 years Hops on one foot

SOCIAL SKILLS

- ❑ 2 mths Smiles
- ❑ 3 mths Reaches for familiar objects
- ❑ 4 mths Plays with hands
- ❑ 6 mths Plays with feet
- ❑ 9 mths Clearly shows joy and pleasure
- ❑ 12 mths Feeds self with fingers
- ❑ 15 mths Plays peek-a-boo
- ❑ 18 mths Understands yes and no

FINE MOTOR SKILLS

- ❑ At birth Primitive grasp reflex present
- ❑ 4 mths Holds & shakes a rattle placed in hand
- ❑ 5 mths Grasps objects independently
- ❑ 6 mths Moves an object from 1 hand to other
- ❑ 6 mths Self-feeding, can hold & eat a cookie
- ❑ 6 mths Checks objects by placing them in Mouth
- ❑ 12 mths Picks up object w/ thumb & index Finger
- ❑ 15 mths Turns 2-3 pages of a book at a time
- ❑ 18 mths Turns pages of a book 1 at a time
- ❑ 24 mths Builds a tower containing at least 5 blocks
- ❑ 4 years Builds a tower containing at least 10 blocks

COMMUNICATION SKILLS

- ❑ 7 wks Makes cooing sounds
- ❑ 3 mths Laughs
- ❑ 5 mths Uses one syllable words, i.e. “da”
- ❑ 8 mths Uses 2 syllable words, i.e. “dada”
- ❑ 12 mths Uses 2 – 3 word vocabulary
- ❑ 24 mths Uses 2 – 3 word phrases

ADAPTIVE SKILLS

- ❑ 10 mths Feeds from a cup unassisted
- ❑ 12 mths Holds own bottle
- ❑ 30 mths Feeds self with utensils
- ❑ 30 mths Able to identify and match some colors
- ❑ 36 mths Copies a circle
- ❑ 42 mths Copies a cross

(MUST BE COMPLETED BEFORE SERVICES CAN BE RENDERED)

CHILD'S FULL NAME ____
SOCIAL SECRUITY NUMBER ____
DATE OF BIRTH ______________________________
CONTACT IN CASE OF EMERGENCY ________________ **PHONE NUMBER** ________________

NAME OF PRIMARY INSRUANCE CARRIER ______________________________________
NAME OF INSURED ____________________ **INSURED DATE OF BIRTH** ____________________
INSURED SOCIAL SECRUITY NUMBER ______________________________

NAME OF SECONDARY INSRUANCE CARRIER ______________________________________
NAME OF INSURED ____________________ **INSURED DATE OF BIRTH** ____________________
INSURED SOCIAL SECRUITY NUMBER ______________________________

INSURANCE POLICIES AND FEE SCHEDULE

Consultation: include practice member history. This service is complimentary.
Assessment (new or established practice member): includes one or more of the following: thermography, postural evaluation, range of motion, motion and/or static palpation, ortho/neuro testing, leg check.
Chiropractic Adjustment: The actual re-alignment of the vertebra done by hand or instrumentation. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place.
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.

***Fee's for services vary depending on the individual's needs, recommendations and insurance coverage.**

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Devan Mahan, DC or Michele Lucassian, DC. I agree that this authorization will cover all services rendered until I revoke that 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 advance. I understand that I am financially responsible for charges not covered by the assignment and that Mahan Family Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I understand that any advertisement/promotional discount offered may not include the entire assessment as described above, chiropractic adjustment or necessary x-rays. Should I decide to proceed with any services not included in advertised/promotional discount, these services will be paid at the normal and customary fees as stated above. I authorize this 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 message, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Signature ____ **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 clinic:

A. **Chiropractic is a very specific science, authored 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 structure 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 out 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 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.**
F. **Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.**
G. **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 _____________

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 (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 physicians' 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 disclosed to carry out treatment, payment, or healthcare 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 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 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 OR GUARDIAN SIGNATURE ________________________________

DATE ______________________________

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD __________________________________

I AUTHORIZE DR. DEVAN MAHAN AND DR. MICHELE LUCASSIAN AND ANY AND ALL MAHAN FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, 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 MAHAN FAMILY CHIROPRACTIC

DATE ____________________

PARENT OR GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD ________________________

WITNESS SIGNATURE (OFFICE STAFF) ______________________________ **DATE** ______________

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.

<u>THE FEE FOR COPYING YOUR X-RAYS AND VIDEO FLUOROSCOPY STUDY ON A DISC IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.</u>

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON AND REGULAR PRACTICE HOUR DAYS.

<u>PLEASE NOTE:</u> 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 DOCTORS OF VITAL LIFE 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 ADVISE.

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

______________________________ ______________________

PRINT YOUR NAME HERE DATE

______________________________ ______________________

PARENT OR GUARDIAN SIGNATURE CHILD'S AGE

<u>FEMALE PATIENTS ONLY:</u> TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT VITAL LIFE 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	☐68	☐1/24	10
☐12-13	☐70	☐1/20	12.5
☐14-15		☐1/15	15
☐16-17		☐1/10	20
		☐2/15	30

MA 300 Size 8x10

☐Cervico-Thoracic

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	5
☐16-17	☐80	☐2/15	7
☐18-19		☐3/20	10
☐20-21		☐2/10	20
☐22-23			

MA 300 Size 8x10

☐Lateral Thoracic

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

MA 300 Size 14x17

☐A-P Thoracic

CM	KVP	Time	MAS
☐16-17	☐75	☐1/20	10
☐18-19	☐80	☐1/15	17
☐20-21		☐1/10	22
☐22-23		☐2/15	30
☐24-25		☐2/10	40
☐26-27		☐1/4	50
☐28-29		☐3/10	75
☐30-31		☐2/5	90

MA 300 Size 14x17

☐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	☐80	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31		☐3/10	50
☐32-33		☐2/5	60
☐30-31		☐1/2	75
☐32-33		☐3/5	80
☐34-35		☐4/5	90
☐36-37		☐1	100
☐38-39		☐1 1/5	120
☐40-41		☐2	150
☐42-43			170

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	170
☐34-35		☐1/2	210
☐36-37		☐3/5	
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 ½	
		☐ 2	

MA 200 Size 14x17

Fluoro: <u>0.25</u> - ______MA; ______ - _____ kvp; _____secs

D.O.B: ________________________________

<u>HR#:</u> ________________________________

X-Ray Height: ______________________________

Additional Notes: ___________________________

____

CA Initials __________