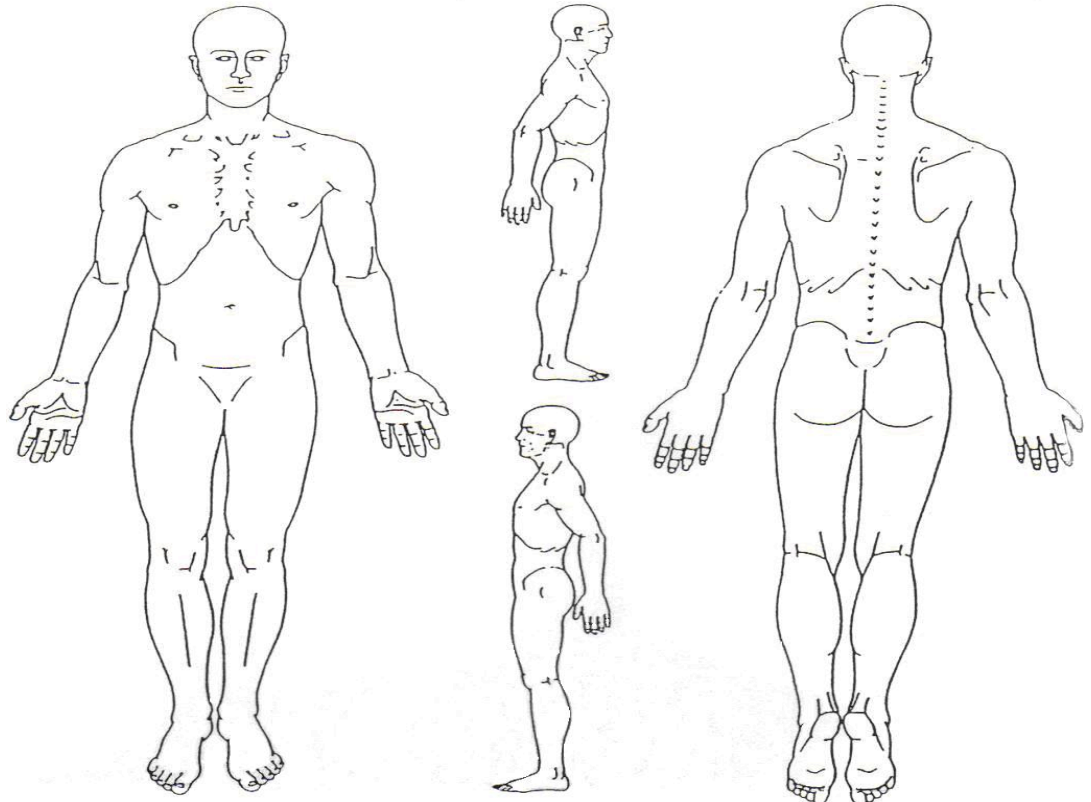


Patient's Name: _____ **Date:** _____
Address: _____ **City:** _____
State/Province: _____ **Zip/Postal Code:** _____
Date of Birth: _____ **Age:** _____ **Gender:** _____ R L Handed
Phone #: _____ **Email:** _____

Please mark the area and type of pain on the drawing using the following code:

- N** – Numbness
- P** – Pain
- T** – Tingling
- A** – Ache
- S** – Soreness
- ST** – Stiffness

Please mark all scars using the following: ++++



Right Left Left Left Right

What are your current complaints? _____

Have you ever been diagnosed with cancer? Y N

Date: _____ Type: _____

Do you have any current diagnoses / diseases / conditions? Y N

List diagnoses / diseases / conditions: _____

Have you had any surgeries? Y N

List surgeries and dates: _____

Have you had any broken bones / fractures? Y N

List bones broken / fractures and dates: _____

Have you had any dental work in the past 2 months? Y N

Type of work and dates (give location – ex. rear upper molars): _____

Have you had a flu, cold, or respiratory illness in the past month? Y N

Do you suffer from any condition other than that which has been listed previously? Y N

If yes, what is it? _____

I have completed this 2-page form to the best of my ability.

Signature: _____ Date: _____

Office Use Only:	Tech: _____	Re-Exam: <input type="checkbox"/> Y <input type="checkbox"/> N
Pt T: _____ F	Rm T: _____ C	
Image Series: <input type="checkbox"/> Upper Body <input type="checkbox"/> Lower Body <input type="checkbox"/> Full Body <input type="checkbox"/> Maxillofacial <input type="checkbox"/> ROI		