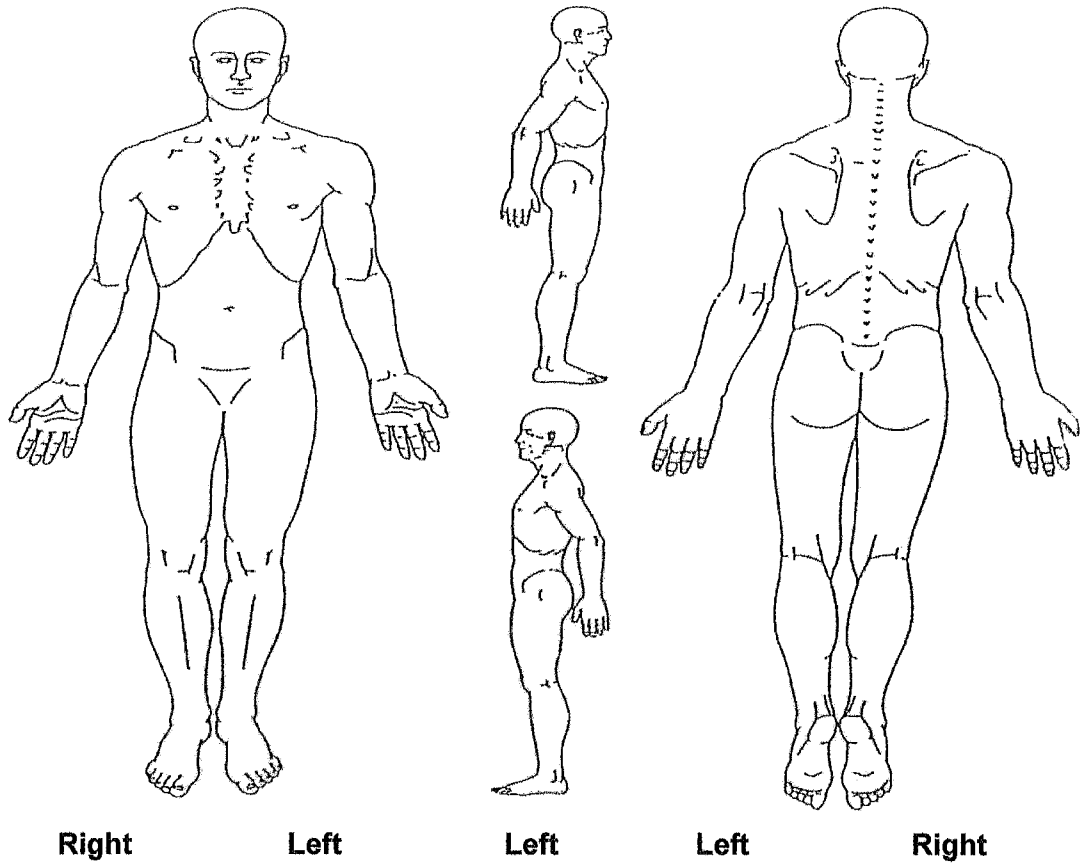


Patient's Name: _____ Date: _____
Address: _____ City: _____
State/Province: _____ Zip/Postal Code: _____
Date of Birth: _____ Age: _____ Gender: _____ R L Handed
Phone #: _____ Email: _____

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: ++++



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		