PROCEDURE AND HISTORY FORM

CHART #: _____ EXAM COMPLETED: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

REFERRING PHYSICIAN: _____

Is there any possibility of pregnancy?

- ☐ Yes
- ☐ No

Date of Injury: _____

- ☐ Work Related Injury
- ☐ Auto Accident
- ☐ Neither: _____

Please briefly describe your symptoms:

_____

_____

_____

_____

_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I consent to treatment as prescribed by my physician.

Signature of Patient: _____ Date: _____

Signature of Technologist: _____