Bel-Ray Wellness Center

CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Nickname: _____ Marital Status: Single Married Widowed

Home Address: _____ City: _____ State: ___ Zip: _____

Home: _____ Cell: _____ Cell Carrier: _____

Email:_____ Text Reminders: Y N *circle one* 4 Hours 1 Day 2 Days
(patient portal & announcements)

Email Reminders: Y N *circle one* 4 Hours 1 Day 2 Days

Date of Birth: _____ Age: _____ Male Female

Race (circle one): American Indian or Alaska native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Daily / Weekly / Occasionally / Former Smoker / Never Smoked

Recreational Drugs Use (Circle one): Heavy Use / Moderate Use / Light Use / Formerly Used / Never Used

Alcohol Consumption (Circle one): Daily / Weekly / Occasionally / Rarely / Do not drink

Daily Caffeine Consumption (Circle one): 40+oz / 16-32oz / 8oz / None

Spouse's Name: _____

Children: 1 2 3 4 5 other ____ Ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who referred you to our clinic**?** _____ *(circle any of the following)*

Physician Friend/Family Newspaper Lunch & Learn Phonebook Walk-In BNI Internet/Social Media Insurance Event

What medication/vitamins are you currently taking? (please include regularly used over the counter medications)

Medication/Vitamin Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

Primary Care Physician: _____

List past surgeries: _____

List past hospitalization: _____

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Employment Information

Employer _____ Occupation _____

Employer's Address _____

How long employed there? _____

Billing Information

Please check any and all insurance coverage that may be applicable in this case

Who will be responsible for your bill? Self Spouse Parent-Guardian Other_____

___Major Medical ___Worker's Compensation ___Medicare ___Auto Accident ___Other

Name of insurance company _____ Name of insured (card holder) _____

Relationship to patient _____ Insured's (card holder's) Social Security Number _____

We will make every effort to help you receive the maximum benefit from your insurance. However, **please remember that your insurance is a contract between you and the insurance company.** We urge you to contact your insurance company to find out *your* benefits. If this is a Worker's Compensation claim, we **must** have prior employer approval before treatment can begin.

Privacy Information

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits directly to the doctor(s) or the clinic office. I authorize the doctor(s) and their staff to release all information necessary to communicate with other physicians and healthcare providers and payors and to secure the payment of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Furthermore, I understand that the records initiated by this clinic on my behalf are the permanent legal property of this clinic. I am entitled to a copy of the records for the prevailing fee.

I hereby give permission to the doctor(s) of McCandless Chiropractic to provide my MD/DO with periodic written and/or verbal updates regarding my health and treatment plan in order to coordinate the best possible care for me.

I authorize the office to discuss any aspects of my case (care, financial, etc.) with the following people:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Patient/Guardian Signature: Date:

_____ _____

McCandless Chiropractic LLC (Bel-Ray Wellness Center)

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of McCandless Chiropractic LLC (Bel-Ray Wellness Center).

Patient's Signature or that of Legal Representative	*Printed Name of Patient or that of Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name	*Today's Date*

Bel-Ray Wellness Center

CONFIDENTIAL

MASSAGE THERAPY INTAKE

CURRENT HEALTH

Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy and type? _____
Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
Do you have any allergies/sensitive skin to oils, lotions, or ointments? Yes No
If yes, please explain _____
Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify _____
Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____
Are you pregnant? Yes No What week?_____ Any challenges?_____
If yes, who is your OB?_____ Have you spoken to them about receiving massage? Yes No

The following sometimes occurs during massage; these are a few of the normal responses to relaxation. Trust your body to express what it needs to: a need to move or change position * sighing * yawning * change in breathing * stomach gurgling * emotional feelings and/or expression * movement of intestinal gas * energy shifts * falling asleep *

RELEASE

Please read carefully and sign below.

1. I understand that the massage/body work I receive is provided for the basic purpose and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request.
2. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a chiropractor, physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose , prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such.
3. Due to the fact that massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand there shall be no liability on the therapist's part should I fail to do so.
4. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled massage appointment.

I give my permission to have massage techniques applied to my person.

Signature _____ Date _____

Therapist _____ Date _____

Consent to Treatment of Minor: By signing below, I hereby authorize the LMT to administer massage or bodywork techniques to my child or dependent as he deems necessary.

Signature of Parent/Guardian _____ Date _____

Bel-Ray Wellness Center

24 Hour Appointment Cancellation Policy

Bel-Ray Wellness Center has a 24 hour massage cancellation / rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged FULL price of the massage.

If we are billing your insurance, there will be a $20 fee added to your account that is not billed to your insurance company.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

Massage Expiration Policy

Any massage purchased, single or 4 packs, will expire one year from date of purchase. Massages not used within one year from purchase date will be forfeited.

_____ _____

Patient Name (printed) Patient/Guardian Signature

_____

Date

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Bel-Ray Wellness Center

REVIEW OF SYSTEMS: PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

MUSCULOSKELETAL:	YES	NO
OSTEOPOROSIS	☐	☐
ARTHRITIS	☐	☐
SCOLIOSIS	☐	☐
NECK PAIN	☐	☐
BACK PROBLEMS	☐	☐
HIP DISORDERS	☐	☐
KNEE INJURIES	☐	☐
FOOT/ANKLE PAIN	☐	☐
SHOULDER PROBLEMS	☐	☐
ELBOW/WRIST PAIN	☐	☐
TMJ ISSUES	☐	☐
POOR POSTURE	☐	☐
NEUROLOGICAL:		
ANXIETY	☐	☐
DEPRESSION	☐	☐
MEMORY ISSUES	☐	☐
SLEEPING ISSUE	☐	☐
HEADACHE	☐	☐
DIZZINESS	☐	☐
PINS AND NEEDLES	☐	☐
NUMBNESS	☐	☐
LOSS OF SMELL OR TASTE	☐	☐
HEAD,EAR, NOSE, THROAT:		
BLURRED/DOUBLE VISION	☐	☐
EARACHE	☐	☐
RECENT HEARING LOSS	☐	☐
RINGING IN THE EARS	☐	☐
CHRONIC EAR INFECTIONS	☐	☐
HOARSENESS	☐	☐

HEAD,EAR, NOSE, THROAT:	YES	NO
SORE THROAT	☐	☐
DIFFICULTY SWALLOWING	☐	☐
CARDIOVASCULAR:		
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
DIZZINESS	☐	☐
HYPERTENSION	☐	☐
HYPOTENSION	☐	☐
HIGH CHOLESTEROL	☐	☐
EXCESSIVE BRUISING	☐	☐
LOWER EXTREMITY SWELLING	☐	☐
RESPIRATORY:		
COUGH	☐	☐
SHORTNESS OF BREATH	☐	☐
ASTHMA	☐	☐
EMPHYSEMA	☐	☐
HAY FEVER	☐	☐
PNEUMONIA	☐	☐
WHEEZING	☐	☐
GASTROINTESTINAL :		
NAUSEA	☐	☐
VOMITING	☐	☐
ABDOMINAL PAIN	☐	☐
HEARTBURN	☐	☐
ULCER	☐	☐
FOOD SENSITIVITIES	☐	☐
CHANGE IN BOWEL HABIT	☐	☐
CONSTIPATION	☐	☐
DIARRHEA	☐	☐
BLOOD IN THE STOOL	☐	☐

GENITOURINARY:	YES	NO
DIFFICULTY URINATING	☐	☐
URINARY FREQUENCY	☐	☐
URGENCY	☐	☐
INCONTINENCE	☐	☐
BLOOD IN THE URINE	☐	☐
ENDOCRINE:		
DIABETES	☐	☐
HEAT/COLD INTOLERANCE	☐	☐
HYPERTHYROIDISM	☐	☐
HYPOTHYROIDISM	☐	☐
PANCREATIC CONDITIONS	☐	☐
ALWAYS THIRSTY	☐	☐
PURPLE STRIAE	☐	☐
DERMATOLOGICAL/ HEMATOPOIETIC:		
NEW RASHES	☐	☐
EASY BRUISING	☐	☐
GUM BLEEDING	☐	☐
BLOOD WITH STOOLS	☐	☐
EXCESSIVE ACNE	☐	☐
ECZEMA	☐	☐
PSORIASIS	☐	☐
SKIN CANCER	☐	☐
EXCESSIVE HAIR LOSS	☐	☐

PAST ILLNESS OF YOURSELF AND FAMILY:

	FAMILY	YOU
AIDS/HIV	☐	☐
ALCOHOLISM	☐	☐
ALZHEIMER'S	☐	☐
ANEMIA	☐	☐
ANOREXIA	☐	☐
ARTHRITIS	☐	☐
ASTHMA	☐	☐
BLEEDING DISORDERS	☐	☐
BREAST LUMP	☐	☐
BRONCHITIS	☐	☐
BULIMIA	☐	☐
CHEMICAL DEPENDENCY	☐	☐
DEPRESSION	☐	☐
DIABETES	☐	☐
EMPHYSEMA	☐	☐
EPILEPSY	☐	☐
HEART DISEASE	☐	☐
HEPATITIS	☐	☐
HERNIATED DISC	☐	☐
HERNIA	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HIGH CHOLESTEROL	☐	☐
KIDNEY DISEASE	☐	☐

	FAMILY	YOU
LIVER DISEASE	☐	☐
MIGRAINE HEADACHES	☐	☐
MISCARRIAGE	☐	☐
MULTIPLE SCLEROSIS	☐	☐
OSTEOARTHRITIS	☐	☐
MULTIPLE SCLEROSIS	☐	☐
OSTEOARTHRITIS	☐	☐
OSTEOPOROSIS	☐	☐
PACEMAKER	☐	☐
PARKINSON'S DISEASE	☐	☐
PINCHED NERVE	☐	☐
PNEUMONIA	☐	☐
POLIO	☐	☐
PREVIOUS CHIROPRACTIC CARE	☐	☐
PROSTATE PROBLEMS	☐	☐
PSYCHIATRIC CARE	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
STROKE	☐	☐
THYROID PROBLEMS	☐	☐
TUMORS	☐	☐
ULCERS	☐	☐
OTHER_____	☐	☐
OTHER_____	☐	☐

RANK YOUR PAIN ON A SCALE FROM 1 TO 10:

(0 being no pain and 10 being the worst pain you have ever felt)

Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Shoulder	0	1	2	3	4	5	6	7	8	9	10
Mid-back	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Elbow	0	1	2	3	4	5	6	7	8	9	10
Wrist	0	1	2	3	4	5	6	7	8	9	10
Hand	0	1	2	3	4	5	6	7	8	9	10
Low-back	0	1	2	3	4	5	6	7	8	9	10
Hips	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Knee	0	1	2	3	4	5	6	7	8	9	10
Ankle	0	1	2	3	4	5	6	7	8	9	10
Foot	0	1	2	3	4	5	6	7	8	9	10

Patient or Guardian Signature: _____ **Date:** _____

Bel-Ray Wellness Center

OSWESTRY-LOW BACK

This questionnaire is designed to enable our doctors to understand how much your low back pain has affected your ability to manage your everyday activities.

PLEASE CHECK ☒ **ONE** ANSWER IN EACH SECTION THAT MOST APPLIES

Name _____

CONFIDENTIAL

OSWESTRY PAIN DISABILITY INDEX QUESTIONAIRE

1. PAIN INTENSITY

- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

2. PERSONAL CARE

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it is very painful.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self care.
- □ I do not get dressed, wash with difficulty and stay in bed.

3. LIFTING

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights, but it causes extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can only lift very light weights, at the most.
- □ I cannot lift or carry anything at all.

4. WALKING

- □ Pain does not prevent me from walking any distance.
- □ Pain prevents me from walking more than one mile.
- □ Pain prevents me from walking more than 1/4 mile.
- □ Pain prevents me from walking more than 100 yards.
- □ I can only walk while using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

5. SITTING

- □ I can sit in any chair as long as I like.
- □ I can only sit in my favorite chair as long as I like.
- □ Pain prevents me from sitting more than 1 hour.
- □ Pain prevents me from sitting more than 1/2 hour.
- □ Pain prevents me from sitting more than ten minutes.
- □ Pain prevents me from sitting at all.

6. STANDING

- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than 1/2 hour.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

7. SLEEPING

- □ My sleep is never disturbed by pain.
- □ My sleep is occasionally disturbed by pain.
- □ Because of pain I have less than 6 hours' sleep.
- □ Because of pain I have less than 4 hours' sleep.
- □ Because of pain I have less than 2 hours' sleep.
- □ Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- □ My social life is normal and causes me no extra pain.
- □ My social life is normal, but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to my home.
- □ I have no social life because of the pain.

9. SEX LIFE

- □ My sex life is normal and causes me no extra pain.
- □ My sex life is normal, but causes some extra pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly absent because of pain.
- □ Pain prevents any sex life at all.

10. TRAVELING

- □ I can travel anywhere without pain.
- □ I can travel anywhere but I gives extra pain.
- □ Pain is bad but I manage journeys over 2 hours.
- □ Pain restricts me to journeys of less than 1 hour.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.

Patient or Guardian Signature _____ Date _____

Bel-Ray Wellness Center

NECK PAIN

This questionnaire is designed to enable our doctors to understand how much your neck pain has affected your ability to manage your everyday activities.

CONFIDENTIAL

PLEASE CHECK ☒ **ONE** ANSWER IN EACH SECTION THAT MOST APPLIES

Name _____

1. PAIN INTENSITY

- □ No pain at the moment
- □ Very mild at the moment
- □ Moderate at the moment
- □ Fairly severe at the moment
- □ Very severe at the moment
- □ Worst imaginable at the moment

2. PERSONAL CARE

- □ Normal without extra pain
- □ Normal with extra pain
- □ Painful and I'm slow / careful
- □ Manage most of my personal care with some help
- □ Need help every day in most aspects of self care
- □ Do not get dressed, wash with difficulty & stay in bed

3. LIFTING

- □ Lift heavy weights, without extra pain
- □ Lift heavy weights, with extra pain
- □ Lift heavy items from a table, but not the floor
- □ Lift moderate items from a table, but not the floor
- □ Lift very light weights
- □ Cannot lift or carry anything

4. READING

- □ As much as I want with no pain
- □ As much as I want with slight pain
- □ As much as I want with moderate pain
- □ Moderate pain prevents reading as much as I want
- □ Sever pain prevents reading as much as I want
- □ Cannot read at all

5. HEADACHES

- □ No headaches
- □ Slight headaches infrequently
- □ Moderate headaches infrequently
- □ Moderate headaches frequently
- □ Sever headaches frequently
- □ Constant headaches

6. CONCENTRATION

- □ Fully concentrate with no difficulty
- □ Fully concentrate with slight difficulty
- □ Fair degree of difficulty concentrating
- □ Lot of difficulty concentrating
- □ Extreme difficulty concentrating
- □ Cannot concentrate at all

7. WORK

- □ Work as much as I want
- □ Can do usual work, but no more
- □ Can do most of my usual work, but no more
- □ Cannot do my usual work
- □ Can hardly do any work at all
- □ Cannot do any work

8. DRIVING

- □ Drive without pain
- □ Drive as long as I want with slight pain
- □ Drive as long as I want with moderate pain
- □ Cannot drive as long as I want due to moderate pain
- □ Hardly drive at all due to severe pain
- □ Cannot drive at all

9. SLEEPING

- □ No trouble sleeping
- □ Sleep is mildly disturbed (less than 1 hour sleepless)
- □ Sleep is mildly disturbed (1-2 hours sleepless)
- □ Sleep is moderately disturbed (2-3 hours sleepless)
- □ Sleep is greatly disturbed (3-5 hours sleepless)
- □ Sleep is completely disturbed (5-7 hours sleepless)

10. RECREATION

- □ Can do all recreational activities with no pain
- □ Can do all recreational activities with some pain
- □ Can do most recreational activities with some pain
- □ Can do a few recreational activities with some pain
- □ Can hardly do any recreational activities
- □ Cannot do any recreational activities

NECK PAIN DISABILITY INDEX QUESTIONAIRE

Patient or Guardian Signature _____ Date _____

Bel-Ray Wellness Center

INFORMED CONSENT FOR CHIROPRACTIC CARE

WHAT TYPE OF CARE ARE YOU SEEKING?

- ☐ **WELLNESS:** Improving overall general health in the absence of acute symptoms.
- ☐ **CORRECTIVE:** Restoring underlying problems while improving symptoms and decreasing pain.
- ☐ **POSTURAL CORRECTION:** Stop the progression of unwanted posture to help muscles function properly, help decrease abnormal wear of joints that could lead to arthritis, prevent backaches and reduce fatigue.
- ☐ **NUTRITIONAL THERAPY:** Promoting optimal health through education, goal setting, supplement recommendations and active lifestyle.
- ☐ **MASSAGE THERAPY:** Enhance function, aid in the healing process, and promote relaxation and well-being.

Chiropractic care, like all forms of health care, while offering considerable benefit 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 artery injury that could lead to stroke.

Prior to receiving chiropractic care at McCandless Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine 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 my consent to the examinations that the doctor(s) at Bel-Ray Wellness Center deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____	_____	_____
Patient Name (printed)	Patient Name (signature)	Date
_____	_____	_____
Legal Guardian Signature	Relationship to patient	Date
_____	_____	
Witness Signature (office staff)	Date	

Bel-Ray Wellness Center

X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may decide that x-rays will be needed in order to help further diagnose your condition and determine the correct treatment. Our clinic requires the patient's or legal guardian's consent before any x-ray procedure is performed.

Please choose <u>ONE</u>:

_____ I understand that my doctor may need x-rays in order to better diagnose my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnose my condition. I choose **<u>NOT</u>** to have any x-rays at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

With those factors in mind, I am advising my doctor that:

I am pregnant	_____Yes _____No _____ I'm not sure
My menstrual period is late	_____Yes _____No _____ I'm not sure
I have an IUD	_____Yes _____No
I have had a tubal ligation	_____Yes _____No
I have had a hysterectomy	_____Yes _____No
I have irregular menstrual periods	_____Yes _____No
I have begun menopause	_____Yes _____No
My last menstrual period began	_____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if my doctor deems it necessary.

Patient/Guardian Signature: _____ Date: _____