

Patient History/Intake Form

Instructions: Please provide information in sections 1, 2 & 3 prior to seeing the technologist (check all that apply)

1 Patient Name: _____ Date of Birth: _____

* **Female Patients:**

Is there any possibility you are pregnant? Yes No Signature: _____

2 Prior Medical Imaging

Have you had recent x-rays of the same body part(s)

Yes
When? _____

Where? _____

No

On the skeleton below: Mark the body part(s) we are x-raying today

Right

Left



Right

Left

3 Check All That Apply and Briefly Explain

Reason for exam today: _____

Trauma/Injury? Yes No

Date of Trauma: _____

Brief Description: _____

Pain,
Where? _____

For how long has it hurt? _____

Does it hurt now? Yes No

...All the time? Yes No

...Occasionally? Yes No

Pre-Surgery,
Date of Surgery: _____

After Surgery,
Date of Surgery: _____

Arthritis
Osteoarthritis? Yes No

Rheumatoid? Yes No

Juvenile? Yes No

Lupus? Yes No

Other? _____

**Hereditary/
Congenital
Condition:** _____

Other: _____

Technologists Only

Area of Interest:	Right	Left	Anterior	Posterior	Medial	Lateral	Notes/Specific Digits/Details
<input type="checkbox"/> Hip(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Knee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hand(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Foot /Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Spine	<input type="checkbox"/> Cervical		<input type="checkbox"/> Thoracic		<input type="checkbox"/> Lumbar		<input type="checkbox"/> Sacral
<input type="checkbox"/> Other:	_____						_____

Comments: _____

Date of exam: _____

Tech Initials: _____ Supervisor initials: _____