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X-RAY PRE-SCREENING FORM

Last Name: ______________________________ First: ______________________________

Date of Birth: ____________________ Sex: ❑ Male ❑ Female

Please indicate if you have any of the following:	YES	NO
Swelling, burning, stabbing, aching, pressure, or radiating pain associated with the injury or the pain?	❑	❑
Previous surgeries/procedures related to your injury or condition?	❑	❑
If female, is there any chance you are or may be pregnant?	❑	❑

- Location of Pain/Body Part Being Examined ______________________________________
- How long have you been hurting? ____
- How did the injury happen? ____

____
Signature of Patient or Guardian Date

____
Signature of Person Conducting Screening Date