Dr.

PATIENT'S TRAVEL LISTINGS	
NAME:	
PRE	POST
Date: ____________ ACDz: ________ AHRy: ________ AXSPy: ________ CSz: ________ AFPz: ________mm	Date: ____________ ACDz: ________ AHRy: ________ AXSPy: ________ CSz:________ AFPz: ________mm

z	y	Leg	MASTOID SUPPORT		C	A	LEG
			HEIGHT	ANGLE	ASP DEGREES		

DIAGNOSIS: ____________

____

____

PRAIMARY DOCTOR'S COMMENTS: ____________

____

____

NEW DOCTOR ____________

FIRST VISIT EXAMINATION CHARGE: ____________

OFFICE VISIT CHARGE: ____________

[ ] Cervical X-rays

[ ] Thoracolumbar X-rays