

RADIOLOGY REPORT

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Patient's Name _____ Age: _____ Sex: _____ Date of Films: _____

REGION IMAGED										
<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Hip	<input type="checkbox"/> Chest	<input type="checkbox"/> Ribs	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral
<input type="checkbox"/> Elbow	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot					

VIEWS TAKEN										
<input type="checkbox"/> Lateral	<input type="checkbox"/> AP	<input type="checkbox"/> APOM	<input type="checkbox"/> Oblique	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Flexion	<input type="checkbox"/> Extension	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral
Other: _____										

ALIGNMENT				
Lordosis	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyper	<input type="checkbox"/> Hypo	
Kyphosis	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyper	<input type="checkbox"/> Hypo	
Gravitational Index Line				
Cervical	<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior	
Lumbar	<input type="checkbox"/> Normal	<input type="checkbox"/> Anterior	<input type="checkbox"/> Posterior	
George's Line	<input type="checkbox"/> Normal	<input type="checkbox"/> Broken at	<input type="checkbox"/> Anterolisthesis	<input type="checkbox"/> Retrolisthesis
Lateral Convexity/Scoliosis	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Apex at:	Degrees:
Leg Length Discrepancy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Femoral head low:	mm
ADI	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased to:	mm	
Spondylolisthesis	Grade: _____ and/or _____ % _____ pars defects/degenerative			
Flexion	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Increased:	
Extension	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Increased:	
	Instability at: _____ with _____ mm translation			
	Instability at: _____ with _____ mm translation			
Other: _____				

BONE			
Mineralization	Adequate	Decreased	Increased
Anomalies Found			
Osteophyte formation on endplates	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Osteophyte formation at posterior facets	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Joint of Luschka spurring	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
IVF narrowing	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Lytic / Blastic changes at			
Vertebral body wedging/compression			
Fracture at			
Other: _____			

CARTILAGE				
Disc space narrowing at	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Joint space narrowing at	<input type="checkbox"/> Normal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Extremity joint space narrowing	<input type="checkbox"/> Uniform	<input type="checkbox"/> Weight Bearing Regions	<input type="checkbox"/> Symmetrical	<input type="checkbox"/> Asymmetrical
Schmorl node formation				
Limbus bone formation				
Other: _____				

SOFT TISSUES				
Organs	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal:		
Vascular calcification	<input type="checkbox"/> Carotid aa	<input type="checkbox"/> Aorta	<input type="checkbox"/> Iliac aa	<input type="checkbox"/> Femoral aa
Extremity joint space narrowing				
Edema/soft tissue swelling				
Other: _____				

Notes

Signature of Provider _____

Date _____

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