



MRI SPINE QUESTIONNAIRE

PATIENT NAME _____

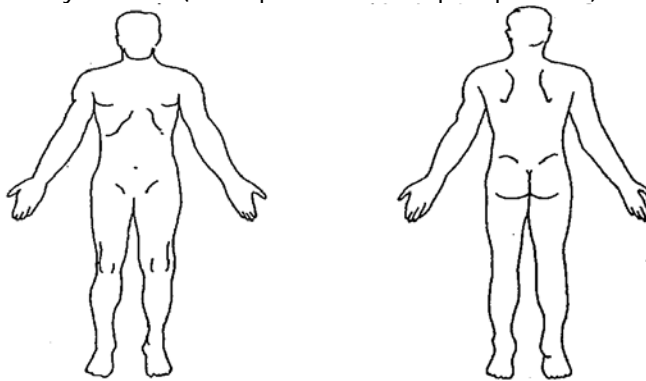
DATE _____ DATE OF BIRTH _____

What is your chief complaint? _____

What were you doing when the pain started (was there a specific injury)? _____

How long have you had the pain (date of injury)? _____

Please indicate your level of pain by number (0=No pain, 10=worst pain possible): _____



PLEASE INDICATE AREAS OF PAIN

Does the pain go down your:

Arm? Yes () No() If yes: Right () Left () Front () Back ()

Leg? Yes () No() If yes: Right () Left () Front () Back ()

Does anything make the pain worse (standing, sitting, etc.)? _____

Do you have:

Numbness? Yes () No () If yes, where? _____

Weakness? Yes () No () If yes, where? _____

History of Cancer? Yes () No () If yes, describe: _____

Bladder Changes? Yes () No () Bowel Changes? Yes () No ()

Have you had spinal surgery? Yes () No () If yes, when and where? _____

What level? _____ Screw/rods implanted Yes() No ()

Do you have any other medical conditions? _____

Have you had any other previous studies for this problem?

MRI Yes() No() Date ___/___/___ Where? _____

CT Yes() No() Date ___/___/___ Where? _____

X-Ray Yes() No() Date ___/___/___ Where? _____

Bone Scan Yes() No() Date ___/___/___ Where? _____