iCare Diagnostic Imaging, LLC
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Suite 160
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CERVICAL/THORACIC SPINE MRI QUESTIONNAIRE

PATIENT WEIGHT_____**PATIENT HEIGHT**_____

INJURY

Work-related Injury _____ Yes _____ No

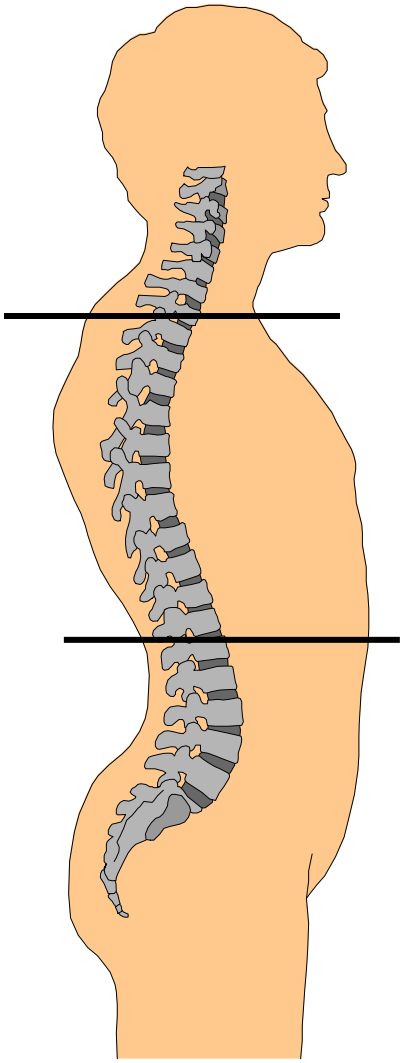
Motor Vehicle Accident _____ Yes _____ No

Sports Injury _____ Yes _____ No

Date of Injury_____

Describe Injury_____

Please indicate below where pain is located.



SYMPTOMS	**Yes**	**No**
Do you have headaches?	____	____
Do you have neck pain?	____	____
Do you have back pain?	____	____
Do you have bowel or bladder incontinence?	____	____

Do you have pain, numbness or tingling in any of the following areas?

(please indicate below)	**Right**	**Left**
Finger pain	____	____
Finger numbness/tingling	____	____
Hand weakness	____	____
Arm pain	____	____
Arm numbness/tingling	____	____
Arm weakness	____	____
Shoulder pain	____	____
Leg weakness	____	____

How long have you had the above symptoms?_____

_____ History of medical disease (Parkinson's Disease, Arthritis, etc.)

Please describe_____

_____ History of cancer (please indicate primary cancer)

Please describe_____

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM

X-Rays	Yes	No	Where_____	Date_____
CT Scan	Yes	No	Where_____	Date_____
MRI Scan	Yes	No	Where_____	Date_____
Myelogram	Yes	No	Where_____	Date_____

Surgery/Arthroscopy

Yes No Where_____ Date_____

What was done? (please specify)_____

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Technologist Use: **Technologist** _____ **Date** _____

Contrast: _____cc of _____ (type) injected into _____ (area).

Notes/Complications

_____

_____

_____

_____

_____

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