iCare Diagnostic Imaging, LLC
2781 Freeway Blvd
Suite 160
Brooklyn Center, MN 55430

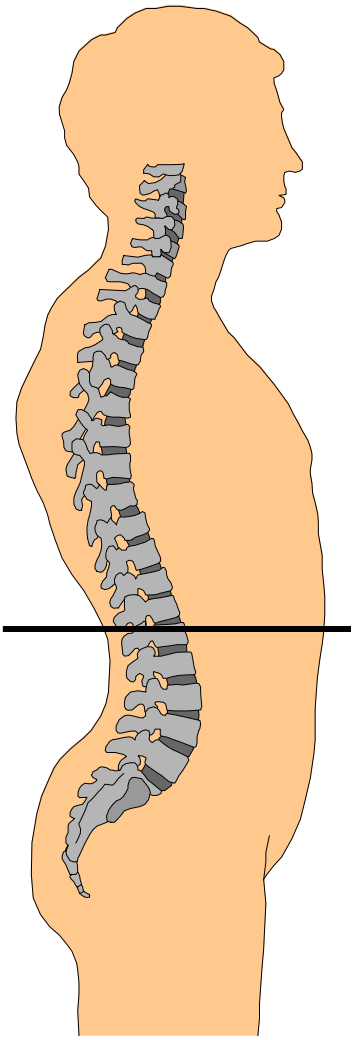
LUMBAR SPINE MRI QUESTIONNAIRE

PATIENT WEIGHT_____ HEIGHT_____

INJURY

Work-related Injury	_____ Yes	_____ No
Motor Vehicle Accident	_____ Yes	_____ No
Sports Injury	_____ Yes	_____ No

Please indicate below where pain is located.



Date of Injury_____

Describe Injury_____

SYMPTOMS	**Yes**	**No**
Do you have low back pain?	____	____
Do you have difficulty in raising your feet?	____	____
Do you have difficulty in lowering your feet?	____	____
Do you unnaturally retain urine?	____	____

Do you have pain, numbness or tingling in any of the following areas? (please indicate below)

	Right	**Left**
Buttocks	____	____
Side of thigh	____	____
Front of thigh	____	____
Back of thigh	____	____
Calf	____	____
Foot near big toe	____	____
Foot near small toe	____	____
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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