PAIN SHEET Musculoskeletal Evaluation

Last Name	First	Middle Init.	Age	Today's Date

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What do you think is wrong ?_____

   _____

2. Describe your symptoms_____

   _____

3. What makes it better?_____

   _____

4. What makes it worse?_____

   _____

5. Do you have areas of weakness?_____Where?_____

6. Have you had surgery or arthroscopy to the area being scanned today?_____

   When?_____What was done?_____

7. Do you have arthritis in any of your joints?_____

   List Joints_____

8. Are you taking any medications?_____What kind?_____

9. Do you have any other medical conditions?_____

   _____

10. List athletic activities that may have contributed to your condition _____

    _____

PLEASE COMPLETE BOTH SIDES

Patient History and Safety Screening

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

Current Weight_____ (Needed for calibration of the MRI machine.)

Have you ever had an MRI with us? If yes, When?_____

YES	NO		
☐	☐	Cardiac Pacemaker	Do you have a follow-up
☐	☐	Brain Vessel Clips	appointment with your Doctor?
☐	☐	Aortic Clips	Yes_____No_____
☐	☐	Artificial Heart Valve	Date: _____Time:_____
☐	☐	Coronary, Artery or Heart Surgery, if yes, when?_____	
☐	☐	Insulin Pump	
☐	☐	Electrodes	
☐	☐	Tens Unit or Pain Stimulating Unit	
☐	☐	Ear Surgery or Implants	
☐	☐	Hearing Aids	
☐	☐	Metal fragments in the head, eye or skin	
☐	☐	Have you ever worked with metal or as a Metal Worker?	
☐	☐	Metal Plates, Pins, Screws, Nails or Clips	
☐	☐	Any previous Skull Surgery If Yes, what was the surgery for:_____	
☐	☐	Is there any chance you are pregnant?	
		(Not recommended for women in their first trimester of pregnancy)	

Signature of Patient:_____

Signature of Parent or Guardian:_____

Date: _____ **PLEASE COMPLETE BOTH SIDES**