PAIN SHEET

Spine Evaluation

Last Name	First	Middle Init.	Age	Today's Date

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your Doctor?_____

   _____

2. What does your Doctor think is causing your spine pain?_____

   _____

3. How long have you had this pain? _____

4. Does the pain go down your arm? _____Leg?_____Back? _____Front?_____

   Left?_____Right?_____Both?_____

5. Do you have any numbness?_____Where?_____

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

6. Have you had any bowel or bladder changes? _____

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

   When?_____What was done?_____

8. Do you have a history of cancer?_____

9. Do you have any other medical conditions?

   _____

   _____

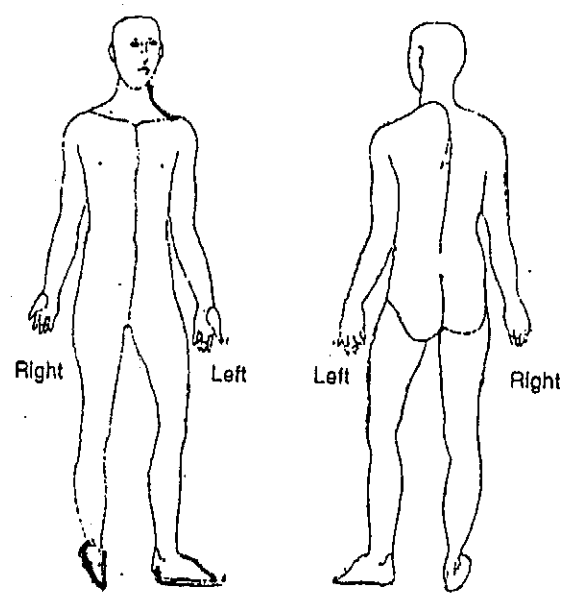
10. List athletic activities that may have contributed

    to your condition _____

    _____

PLEASE COMPLETE BOTH SIDES

PLEASE SHADE IN THE AREAS WHICH HURT.



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**