SPINE IMAGING

Patient Name________________________ DOB__ /___/___ Weight ____Height____

Address____ SS#______-_____-______

Phone____________________ Cell___________________ Work__________________

CERVICAL THORACIC LUMBAR

Please circle the appropriate answer for the following :

Have you had an injury? YES NO if yes, Date of injury_____________

Have you had spine surgery? YES NO if yes, Date ___________________

Have you had any other studies of your spine? YES NO
(X-rays, CT scans, Bone scans, etc…)
if yes, When and Where were they done?________________________________
____

Do you have neck pain?	YES	NO		
Arm/hand pain?	YES	NO	RT	LT
Shoulder pain?	YES	NO	RT	LT
Mid back pain?	YES	NO	RT	LT
Lower back pain?	YES	NO	RT	LT
Buttock pain?	YES	NO	RT	LT
Leg pain?	YES	NO	RT	LT

Do you have a history of cancer YES NO Radiation or Chemotherapy
If yes, please explain____

Please EXPLAIN the location of pain and/or movement that causes pain
____
____
____
____

____________________________ ____________________ _____/_____/_____
Signature of Person Completing Form Relationship to Patient Date