HTPN DALLAS DIAGNOSTIC ASSOCIATION

MAGNETIC RESONANCE IMAGING (MRI)
SPINE QUESTIONNAIRE

Print Name:_____ **Date:**_____

1) Reason you are having this MRI scan, include any recent or new complaints:_____
_____
How long have your symptoms been present?_____

2) Are you having neck or back pain? ☐ Yes ☐ No
If yes, where? (Please Check) ☐ neck ☐ upper-back ☐ mid-back ☐ lower-back

3) Does your pain radiate (shoot down) your arms or legs? ☐ Yes ☐ No
If yes, where? (Please Check) ☐ Right Arm ☐ Left Arm ☐ Both
☐ Right Leg ☐ Left Leg ☐ Both
If yes, how far down does the pain radiate? (elbow, hand, knee, foot, etc.)_____

4) Are you experiencing any numbness? ☐ Yes ☐ No
If yes, where?_____

5) Have you had surgery on your neck or back? ☐ Yes ☐ No
If yes, which part of your neck or back? (Please Check) ☐ neck ☐ upper-back ☐ mid-back ☐ lower-back

6) Do you have a history of cancer? _____ If yes, what type? _____
Did the treatment include:
Radiation Therapy? ☐ Yes ☐ No
Chemotherapy? ☐ Yes ☐ No
If yes to radiation therapy, what part of your neck or back? _____

7) Do you have any chronic or long-term illnesses?_____

8) Have you had any other types of previous surgery?_____ If yes, list the type of surgery and date:
_____ _____
_____ _____

9) Have you had any previous imaging studies of your neck or back? ☐ Yes ☐ No
* If yes, please indicate:

Type of Study:	**Date**	**Facility**
Radiographs (X-rays)	_____	_____
Myelogram	_____	_____
Computed Tomography (CT)	_____	_____
Nuclear Medicine (Bone Scan)	_____	_____
MRI	_____	_____
Other	_____	_____

MRI Technologists Notes:

_____
_____
_____