HTPN DALLAS DIAGNOSTIC ASSOCIATION

MAGNETIC RESONANCE IMAGING (MRI) SPINE QUESTIONNAIRE

eason you are having this MRI scan, incluous long have your symptoms been preserve you having neck or back pain? Yes, where? (Please Check)	ent?es □ No	·	
re you having neck or back pain? □ Ye	ent? es □ No		
	on appointed	k □ mid-back □ lower-back	
oes your pain radiate (shoot down) your a	arms or legs? □ Y	′es □ No	
yes, where? (Please Check) ☐ Rig	ght Arm □ Left A	rm □ Both	
-	, ,	· ·	
ave you had surgery on your neck or bac	k? □ Yes □ I	No	
yes, which part of your neck or back? (Pl	lease Check) 🛚 n	eck □ upper-back □ mid-back	□ lower-back
o you have a history of cancer? Did the treatment include:	If yes, what t	ype?	
Radiation Therapy? ☐ Yes	s □ No		
• •		?	
you have any chronic or long-term illnes	ses?		
ve you had any other types of previous s	surgery? If	yes, list the type of surgery and da	te:
f yes, please indicate:	•		
adiographs (X-rays)			
omputed Tomography (CT)			
uclear Medicine (Bone Scan) RI ther			
	yes, how far down does the pain radiate? The you experiencing any numbness? If yes, where? The you had surgery on your neck or back yes, which part of your neck or back? (Proposition of the treatment include: Radiation Therapy? If yes to radiation therapy, what part of you have any chronic or long-term illness ye you had any other types of previous so yes, please indicate: The you had any previous imaging studies for yes, please indicate: The of Study: The you had any previous imaging studies for yes, please indicate: The of Study: The you had any previous imaging studies for yes, please indicate: The of Study: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The you had any previous imaging studies for yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The you have any chronic or long-term illness yes, please indicate: The young have any chronic or long-term illness yes, please indicate: The young have any chronic or long-term illness yes, please indicate: The young have any chronic or long-term illness yes, please indicate: The young have any chronic or long-term il	□ Right Leg □ Left Leg □ Left Leg □ Left Leg □ Right Le	□ Right Leg □ Left Leg □ Both yes, how far down does the pain radiate? (elbow, hand, knee, foot, etc.) e you experiencing any numbness? □ Yes □ No If yes, where? ave you had surgery on your neck or back? □ Yes □ No yes, which part of your neck or back? (Please Check) □ neck □ upper-back □ mid-back o 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? □ you have any chronic or long-term illnesses? □ ve you had any other types of previous surgery? □ If yes, list the type of surgery and da ve you had any previous imaging studies of your neck or back? □ Yes □ No if yes, please indicate: □ pe of Study: □ Date □ Facility □ clear Medicine (Bone Scan) □ If yes, list the type of Study: □ Date □ Study: □ Date □ Study: □ Date □ Study: □ Date