



MRI SPINE PATIENT HISTORY

Date: _____

Delaney No. _____

Name: _____ Sex: M F Age: _____

PLEASE TRY TO ANSWER ALL QUESTIONS

What is your present complaint or problem?

About how long ago did it start? _____

Did you injure your back or neck? Yes No

Were any bones broken? Yes No

Did the injury occur at work? Yes No

Have you had any surgery on your back or neck? Yes No

When? _____ Where? _____

Have you had a recent related CT scan, MRI or Myelogram? Yes No

When? _____ Where? _____

What were you told it showed? _____

Does anything make it worse? (Standing, Sitting, Lying Down, etc.) _____

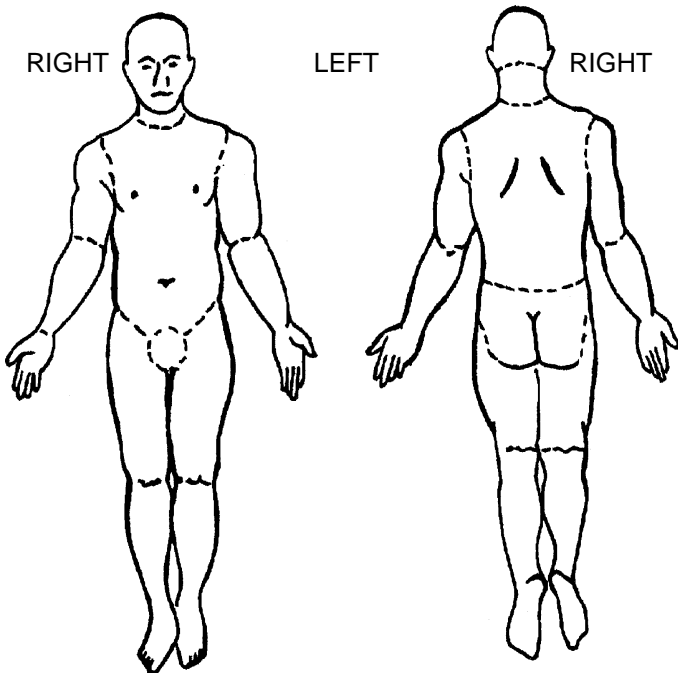
Do you have weakness? Yes No

Do you have numbness? Yes No

Have you had any bowel or bladder changes? Yes No

Do you have a history of cancer? Yes No

If yes, what type? _____



Please shade in the areas of pain or symptoms that has prompted this MRI.

Patient Signature _____

Date _____

Technologist Signature _____

Date _____