



Date: _____

Patient Questionnaire Please use a Black Ink pen

Patient Name: _____ Age: _____

Physician's name that sent you for this exam: _____

Problems / Treatment Received

What problem are we evaluating today? _____

What are your symptoms? _____

When did your symptoms start? _____

If you have a specific injury that caused your symptoms, please explain? _____

Medical History

If you ever had surgery on the body part we are scanning, what surgery, and what date? _____

Have you had any broken bones in the area being scanned today? _____

Have you ever had cancer? If yes what type and when: _____

Chemotherapy? _____ Radiation? _____

If this exam is for your spine:

Does the pain go into your arm(s)? _____ Right, Left, Both? (Please circle one)

Does the pain go into your leg(s)? _____ Right, Left, Both? (Please circle one)

Any associated numbness? Where? _____

Any associated weakness? Where? _____

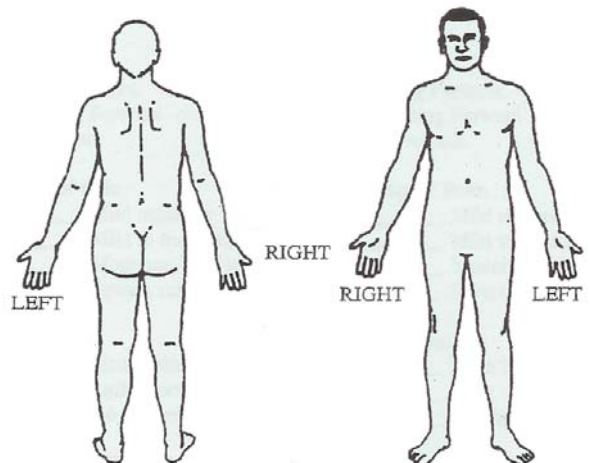
Any bowel or bladder changes? Describe. _____

Any previous neck or back (spinal) surgery? What was done and when? _____

For Women?

Date of last menstrual period: _____

Is it possible that you may be pregnant? _____



Locate your symptoms: Please
Locate the area of your symptoms
On the diagram to the right