1. What was your chief complaint when you visited your doctor? ______________________
__________________________________________________________________________

2. Has the pain been longer than 6 weeks?  □ Yes  □ No

3. What do you think caused the problem? ________________________________
__________________________________________________________________________

4. What does your doctor think is causing your pain? ________________________
__________________________________________________________________________

5. Describe your pain (e.g., burning, sharp etc.) ____________________________
__________________________________________________________________________

6. Does the pain go down your arm? _____  Your leg? _____  In the back or front? _____
Left, right or both? _______________________________________________________

7. a. Does anything make the pain worse (e.g. standing, sitting, lying down etc.)? ______
__________________________________________________________________________

b. Does anything make it better?  ____________________________________________
__________________________________________________________________________

8. Do you have any numbness? ______  Where? _________________________________

9. Do you have any weakness? ______  Where? _________________________________

10. Have you had any bowel or bladder changes? ______  Describe: ________________
__________________________________________________________________________

11. Have you had surgery to the area being scanned today?
__________________________________________________________________________

12. Do you have any more medical conditions? __________
__________________________________________________________________________

13. Do you exercise regularly? _______ Type? __________
__________________________________________________________________________

14. Describe your general health: _______________________
__________________________________________________________________________

PLEASE SHADE IN THE AREAS WHICH HURT

Right               Left              Left               Right

DIAGNOSTIC IMAGING - MRI SPINE EVALUATION FORM

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