ADVANTAGE+ MRI
Excellence in High Field Imaging

MRI Patient Clinical History
Spine

Name: _____ Date: _____

Please indicate if these symptoms are the result of the following:

Auto Accident ( ) **Personal Injury** Other than auto accident ( ) **Work Injury** ( ) **Illness** ( )

When did the accident happen (date): _____

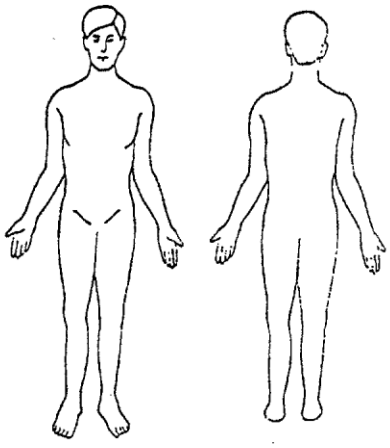
When did your symptoms begin: _____

YES NO Do you experience or have the following?

( ) ( ) Previous surgery to your spine Where: _____ When: _____
( ) ( ) Cervical (neck) pain
( ) ( ) Thoracic (mid back) pain
( ) ( ) Lumbar (lower back) pain
( ) ( ) Headache

YES NO Please indicate the body location that you experience symptoms.

( ) ( ) Shoulder, Elbow, Hand, Wrist, Fingers Right Left
( ) ( ) Buttock (s), Hip, Leg, Knee, Ankle, Foot, Toes Right Left
( ) ( ) Weakness?
Where: _____
( ) ( ) Paralysis?
Where: _____
( ) ( ) Loss of Sensation?
Where: _____
( ) ( ) Tingling and / or Prickling?
Where: _____
( ) ( ) Tremor or Spasm?
Where: _____
( ) ( ) Lack of Coordination?
( ) ( ) Difficulty in walking or limp?
( ) ( ) Mass, swelling, lump?
Where: _____
( ) ( ) Abnormal Posture?
( ) ( ) History of Multiple Sclerosis?



Other symptoms or complaints: _____

( ) ( ) Previous surgery to this body location

Procedure: _____ When? _____

( ) ( ) Have you had any prior Xrays, CT Scan, Ultrasound or Nuclear Medicine exams for this area?

What facility: _____

( ) ( ) Have you had cancer? Type: _____

What was done? Surgery Chemotherapy Radiation Therapy

Date of Surgery: _____ Date of therapy: _____

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Signature: _____ Date: _____