ADVANTAGE+ MRI
Excellence in High Field Imaging

MRI Patient Clinical History
Spine

Name: _____ Date: _____

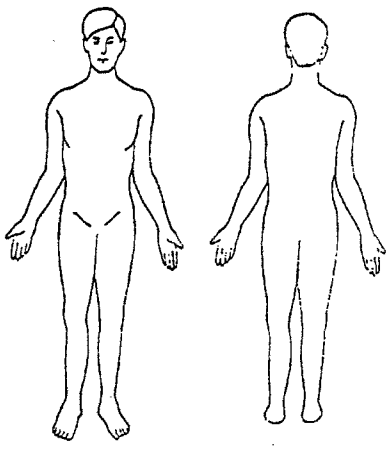
Please indicate if these symptoms are the result of the following:

Auto Accident ( ) Injury ( ) Illness ( )

When did your symptoms start or accident happen: _____
How did this injury occur? (Describe what happened) _____
Please answer all questions that pertain to today's examination.

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?

Where: _____

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

What was done? Surgery Chemotherapy Radiation Therapy

Date of Surgery: _____ Date of therapy: _____