

MRI Evaluation

Name	Date of Birth
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Email

Describe your symptoms

How long have you had those symptoms?

What treatments have you tried?

Physical Therapy
 Surgery
 Injections
 Exercise
 Chiropractic
 Massage
 None

MRI Brain (Check off any of the following symptoms you are experiencing)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> History of stroke. Describe _____
<input type="checkbox"/> Seizure	<input type="checkbox"/> Vertigo	<input type="checkbox"/> History of cancer. Describe _____
<input type="checkbox"/> Syncope	<input type="checkbox"/> Slurred speech	<input type="checkbox"/> History of trauma. Describe _____
<input type="checkbox"/> Off balance	<input type="checkbox"/> Aphasia (language)	<input type="checkbox"/> Body numbness or weakness <input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Blurred/Doubled vision	<input type="checkbox"/> Facial numbness <input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Confusion	<input type="checkbox"/> Altered or loss of smell	<input type="checkbox"/> Hearing loss <input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Ataxia (coordination)	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Tinnitus <input type="radio"/> L <input type="radio"/> R

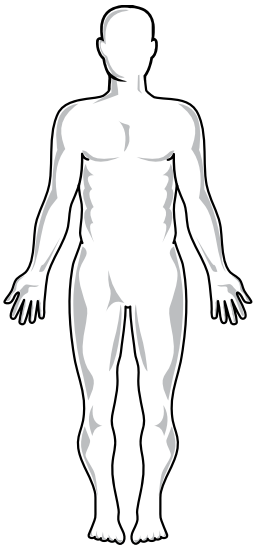
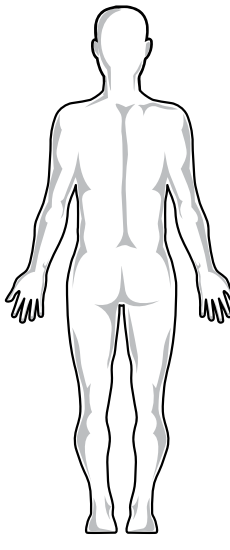
MRI Spine / Extremity
 (Check off any of the following symptoms you are experiencing)

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Arm pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Hand/finger pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Hip pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Right flank pain	<input type="checkbox"/> Leg pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Left flank pain	<input type="checkbox"/> Foot/toe pain	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Arm numbness	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Finger numbness	<input type="radio"/> L <input type="radio"/> R
<input type="checkbox"/> Pelvic/groin pain	<input type="checkbox"/> Leg numbness	<input type="radio"/> L <input type="radio"/> R

Trauma _____

Surgery _____

Please shade in areas which hurt

Front
Back

Continued on Next Page →

Please tell us whether or not you have a history of any of the following medical conditions:

- Cardiac Pacemaker Yes No
- Brain Aneurysm Clips Yes No
- Eye Implants Yes No
- Ear Implants Yes No
- Hearing Aid Yes No
- Vascular/Surgical clips Yes No
- Shunts/Stents Yes No
- Pumps Yes No
- Prosthesis Yes No
- Wire Sutures Yes No
- Any Type of Stimulator (ie, Tens Unit) Yes No
- Any Type of Foreign Body, Bullet, Iron Yes No
- An IUD or Pessary Yes No
- Dentures, or a Dental Bridge or Implant Yes No
- Tattoo Eyeliner Yes No

Comments

Is there any chance there could be metal in your eye? (Do you work with metal welding, cutting or grinding?)

- Yes No

Do you have a history of cancer?

- Yes No

Are you pregnant or a nursing mother?

- Yes No

The date of your last menstrual period _____

Any previous surgery?

- Yes No

If yes, what kind and when _____

Have you had any other testing for this problem? MRI CT X-ray

Is this a work related injury?

- Yes No

If yes, date of injury _____

Is this related to a motor vehicle accident?

- Yes No

If yes, date of accident _____

Is there litigation pending?

- Yes No

Comments

Patient Signature

Date

Technologist Signature

Date