

SPINE

Name _____ Date _____

Age _____ Weight _____

Area of the spine to be scanned: (Please circle) CERVICAL, THORACIC, LUMBAR

Please give a brief description of your symptoms related to the area to be scanned:

Neck Pain	Left _____	Right _____	Arm Pain	Left _____	Right _____
Back Pain	Left _____	Right _____	Leg Pain	Left _____	Right _____
Tingling	Left _____	Right _____	Weakness	Left _____	Right _____

How long have you had these symptoms?

Was the onset of your symptoms related to an injury?

Was the onset of your symptoms related to work or job?

Any incontinence (loss of bowel or bladder control)?

Do you have any history of cancer? Yes _____ No _____

If yes, what type and when? _____

If yes, have you received radiation therapy? Yes _____ No _____ When _____

Have you had any surgery on your spine? Yes _____ No _____

If yes, indicate what level (if known) _____ When _____

Did the surgery help your symptoms? _____

Prior scans (for the area being scanned today):

CT	Yes _____	No _____	When _____	Where _____
MRI	Yes _____	No _____	When _____	Where _____
X-ray	Yes _____	No _____	When _____	Where _____
Myelograms	Yes _____	No _____	When _____	Where _____
Bone Scans	Yes _____	No _____	When _____	Where _____

Technologist: _____