DMI Dynamic Medical Imaging

Stand-up MRI
CT
Ultrasound
X-Ray

CERVICAL SPINE CT/MR QUESTIONNAIRE

***Today's Date:*___________________**

Name__________________________DOB__________________AGE____________

What complaints or symptoms lead you to see your doctor?_______________________

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How long have you had these symptoms?_____________________________________

Have you ever had trauma or injury to your neck?_________When?_________________

If you suspect trauma or injury to have caused this pain, please describe how it

occurred:____

____.

Do you have neck pain?_______For how long?________________________________

Do you have pain, numbness or tingling in any of the following areas? Please check where appropriate:

	LEFT	RIGHT
Upper arm	____	_____
Elbow	____	_____
Lower arm	____	_____
Hands/Fingers	____	_____

Please list any other medical problems that you have, or have had in the past:

____

____:

____

Please list any and all medications you are currently taking:

____

____

____

Patient's Signature____