Brain & Spine MRI Center

Patient Name:_____ Date of Birth:_____

Date:_____

SPINE EVALUATION

1. Describe what made you seek medical advice: _____
2. What does your doctor think is causing your back pain? _____

   _____
3. How long have you had this pain? _____
4. Does the pain go down your arm? YES NO

   If you answered yes what side? RIGHT LEFT BOTH
5. Does the pain go down your leg? YES NO

   If you answered yes what side? RIGHT LEFT BOTH
6. Do you have any numbness? YES NO

   If you answered yes, please describe: _____
7. Do you have any weakness? YES NO

   If you answered yes, please describe: _____
8. Have you had any bowel or bladder changes? YES NO
9. Have you had surgery in regards to the scan being done? YES NO

   If yes please describe what type of surgery, date and where surgery was done:

   _____
10. Do you have a history of cancer? YES NO Type: _____
11. Do you have any other medical conditions? _____

    _____