

PAIN SHEET

Spine Evaluation

Name			Birth date	Referred by	Today's Date
_____/_____/_____ Last First Middle Init.			____/____/____ mm/dd/yyyy	Dr. _____	____/____/____ mm/dd/yyyy

1. What was your chief complaint when you visited your doctor? _____

2. What do you think caused the problem? _____

3. What does your doctor think is causing your back pain? _____

4. Describe your pain (e.g., burning, sharp, etc.) _____

5. Does the pain go down your arm? _____ Your leg? _____ In the back or front? _____
Left, right or both? _____
6. a) Does anything make the pain worse (e.g., standing, sitting, lying down, etc.)? _____

- b) Does anything make it better? _____

7. Do you have any numbness? _____ Where? _____

8. Do you have any weakness? _____ Where? _____

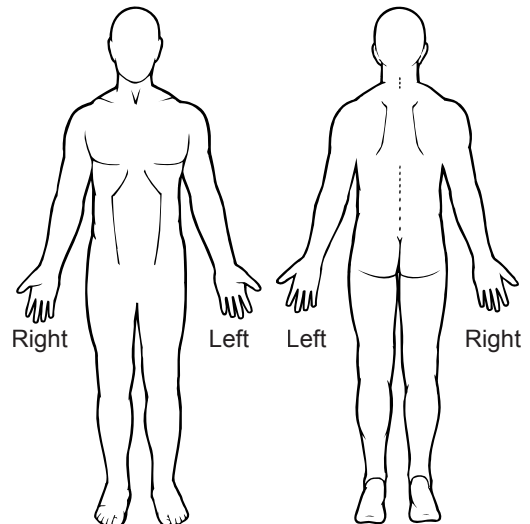
9. Have you had any bowel or bladder changes? _____ Describe: _____
10. Have you had surgery to the area being scanned today? _____
When? _____
What was done? _____

Please indicate the area of interest, the location of any mass, or any area that hurts...

11. Are you taking any medicines? _____
What kind? _____
12. Do you have any other medical conditions? _____

13. Do you exercise regularly? _____ What type? _____

14. Describe your general health: _____



Please complete BOTH sides.

Patient History and Safety Screening
MRI PATIENTS ONLY

Please answer all of the following questions:

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CARDIAC PACEMAKER |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN VESSEL CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | AORTIC CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> | <input type="checkbox"/> | CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INSULIN PUMP |
| <input type="checkbox"/> | <input type="checkbox"/> | ELECTRODES |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS UNITS OR PAIN STIMULATING UNIT |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR SURGERY OR IMPLANTS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL FRAGMENTS IN THE HEAD, EYE OR SKIN |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER? |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL PLATES, PIN, SCREWS, NAILS OR CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY PREVIOUS SKULL SURGERY |

If yes, what was the surgery for: _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS THERE ANY CHANCE YOU ARE PREGNANT?
(Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

Signature of patient: _____

Signature of parent or guardian: _____

Date: _____

Please complete BOTH sides