North Dover OPEN MRI
"As OPEN As It Gets"

CERVICAL SPINE CT/MR QUESTIONNAIRE

Today's Date:_____

Name_____DOB_____AGE_____

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

_____

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_____