SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MRI ADVANCED SPINE

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____.

Height _____ Weight _____ Patient# (*Internal Use Only*) _____

REASON FOR EXAM *(Please include symptoms and time frame):*

Previous Imaging Studies Related to Todays Exam	**Date**
Previous Surgeries Related to Todays Exam	**Date**

TECH NOTES *(for internal use only)*:

Sedation:	
MRI Safety:	

Guerbet Dotarem Contrast:

_____ from _____ **vial**

Additional Notes:

Is your area of concern related to an injury? ☐ **Yes** ☐ **No** **If yes, continue below:**

Date of Injury _____ **How were you injured?** ☐ **Car Accident** ☐ **Work** ☐ **Other**

Describe Injury *(please be specific)* _____

Have you ever been diagnosed with Cancer? ☐ **Yes** ☐ **No** **If yes, continue below**

What type of cancer? _____ **Location:** _____

Date diagnosed: _____ **Current status:** ☐ **Newly Diagnosed** ☐ **Remission** ☐ **Recurrence**

Treatment: ☐ **Surgery** ☐ **Radiation** ☐ **Chemo** ☐ **Other treatment(s):** _____

Date of Last Treatment: _____ **Has it spread?** ☐ **Yes** ☐ **No** **If yes, where?** _____

Is your visit today related to this cancer? ☐ **Yes** ☐ **No**

Have you ever been diagnosed with Multiple Sclerosis? ☐ **Yes** ☐ **No** **If yes, when?** _____

Please complete the below for all that apply:		**How Long?** *Example: 2 years*
Neck pain	☐ **Yes** ☐ **No**	
Mid Back Pain	☐ **Yes** ☐ **No**	
Low Back Pain	☐ **Yes** ☐ **No**	

Please complete the below for all that apply:			**How Long?** *Example: 2 years*
Arm Numbness/Pain	☐ **Yes** ☐ **No**	☐ **Right** ☐ **Left** ☐ **Both**	
Leg Numbness/Pain	☐ **Yes** ☐ **No**	☐ **Right** ☐ **Left** ☐ **Both**	
Arm Weakness	☐ **Yes** ☐ **No**	☐ **Right** ☐ **Left** ☐ **Both**	
Leg Weakness	☐ **Yes** ☐ **No**	☐ **Right** ☐ **Left** ☐ **Both**	

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____