

MRI Body/Limbs

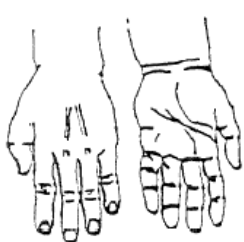
Chest, Abdomen/Pelvis, Hip
 Spine (Cervical/Thoracic/Lumbar)
 Hand/Wrist

Upper Extremity (Shoulder/Arm)
 Lower Extremity (Knee, Thigh, Calf, Ankle, Foot)

Name		Acct #		Date	
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	No	Yes	If yes, explain/list when indicated
Do you have pain?			
Where is the pain?			
How frequent is the pain?			
Have you had other tests for this present problem?			
Is this the result of an injury?			
Medical Problems			
Did you take any medication for sedation or to relax you today?	No	Yes	
If yes, what?			

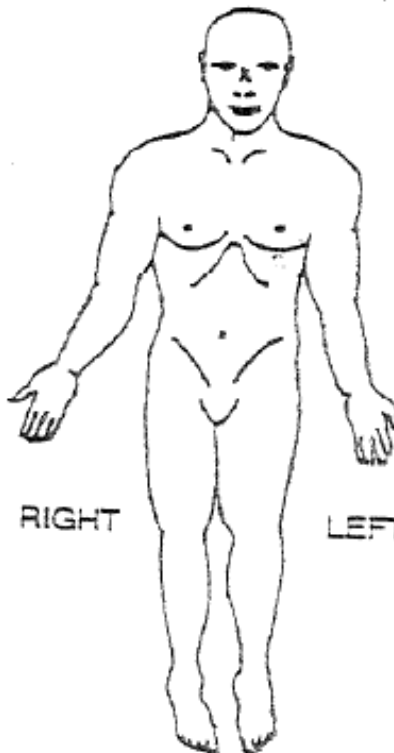
Please shade in area(s) affected by pain or numbness



Left

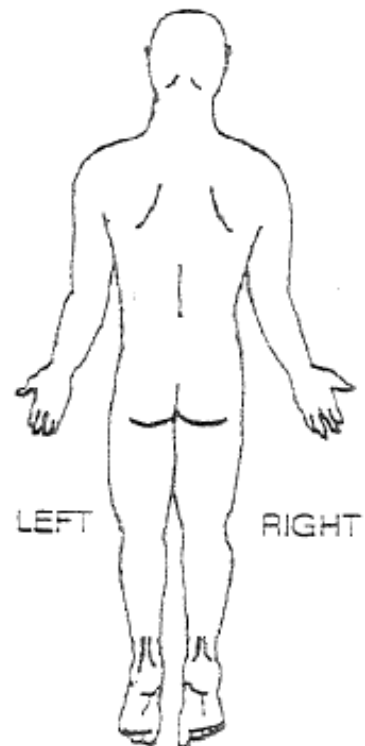


Right



RIGHT

LEFT



LEFT

RIGHT

Date _____ Patient Signature _____ /Signature of patient's representative _____
 (Relationship: Parent (minor under 18 years) Court appointed Guardian)

Technician Review & Signature _____