PATIENT CLINICAL QUESTIONNAIRE

All questions are pertaining to exam(s) being performed today

ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. THIS FORM WILL BE SUBMITTED TO YOUR INSURANCE COMPANY FOR BILLING PURPOSES

NAME:	**DOB:**
HEIGHT:	**WEIGHT:**
POSSIBILITY OF PREGNANCY?	**BREASTFEEDING?**

Describe your symptoms, location of the pain, cause of accident and date of injury.

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Have you had surgery on the area being scanned? □ Yes □ No If yes, please list dates and description.

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Have you had prior diagnostic testing (X-rays, CTs, MRIs) on the area being scanned? □ Yes □ No If yes, please list dates and exam type.

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Have you had chemotherapy or radiation therapy in the area being scanned? □ Yes □ No If yes please list dates.

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Check all that apply

Neck Pain	□ Right □ Left
Arm Pain	□ Right □ Left
Arm Weakness	□ Right □ Left
Arm Numbness	□ Right □ Left
Arm Tingling	□ Right □ Left
Back Pain	□ Right □ Left
Leg Pain	□ Right □ Left
Leg Weakness	□ Right □ Left
Leg Numbness	□ Right □ Left
Leg Tingling	□ Right □ Left

Do you have any of the following medical conditions?

□ Asthma	□ Heart Disease
□ Bells Palsy	□ Hysterectomy
□ Bleeding Disorder	□ Kidney Disease
□ Blurred Vision	□ Liver Disease
□ Buzzing/Ringing in Ears	□ Lung Disease
□ Cancer	□ Multiple Myeloma
□ Diabetes	□ Memory Loss
□ Hearing Loss	□ Pancreatic Disease
□ Headaches	□ Prostate Disease
□ Head Trauma	□ Seizures
□ TMJ Problems	□Vertigo
□ Gall Bladder Disease	