



Housatonic Valley Radiological Associates

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Community Based Imaging Excellence for Over 25 Years

Accredited by the American College of Radiology

CERVICAL MRI QUESTIONNAIRE

Name _____ Acct # _____
Date of Birth _____ SS# _____ Sex (M/F) _____ Age _____

Pertaining to your CERVICAL SPINE, have you ever had...

Previous MRI? _____ Where: _____ When: _____
Previous CT Scan? _____ Where: _____ When: _____
Previous Mylogram? _____ Where: _____ When: _____

Background / Symptoms:

Are you experiencing...

Pain? YES NO Numbness? YES NO Weakness? YES NO Tingling? YES NO

Location of Symptoms: Right _____ Left _____ Both Sides _____ Arms/Hands _____

Are your symptoms the result of an accident or injury? YES NO

If YES, please describe: _____

Duration of Symptoms: Days _____ Weeks _____ Months _____ Years _____

What does your doctor think is wrong? _____

Have you ever had surgery on your neck? YES NO What Level? _____

If YES, which facility _____ By Whom _____ When _____

Do you take medication? YES NO What kind? _____

Please shade in area(s) of pain:

