

Trinitas Diagnostic Imaging

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Cervical Spine Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

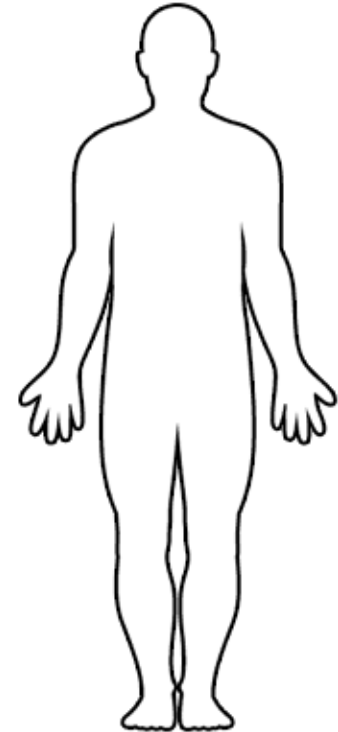
AGE

WEIGHT

DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHAT DO YOU THINK CAUSED THE PROBLEM?



Please circle the portion of your body that is in pain.

DOES THE PAIN GO DOWN YOUR ARM? YES NO

(IF YES, WHICH ONE?):

DO YOU HAVE ANY NUMBNESS OR WEAKNESSES? YES NO

(IF YES, WHERE?):

HAVE YOU HAD SPINE SUREGERY ? YES NO

(IF YES, WHEN AND WHAT WAS DONE?):

ANY OTHER MEDICAL CONDITIONS? YES NO

IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR GENERAL HEALTH: