Name: ______________________ MRN: ______________________

Please Fill Out to the Best of Your Knowledge

Area Being Imaged: ______________________

Please Describe Your Symptoms/Reason You Are Here Today: ______________________

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Exact Location of Pain or Symptom: ______________________

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Does the Pain Radiate or Travel Anywhere? ______________________

____

Location of Numbness/Tingling: ______________________

How Long Have You Been Having These Symptoms? ______________________

Did You Have Any Injury that Caused Your Symptoms?
If Yes, Specify Details (Fall Off Bike, Rollover Mva Unrestrained, etc.): ______________________

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When Was the Injury? ______________________

Previous Surgery to this Body Part? *If Yes, Surgery Type and Date:* ______________________

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Previous Diagnosis of Cancer?
If Yes, Specify Details (Type of Cancer, Date Diagnosed, and All Treatments): ______________________

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