CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

X-RAY/CT/MRI NEURO QUESTIONNAIRE

PATIENT I.D.

1. What is your main symptom/problem?

❑ Injury ❑ Pain ❑ Headache ❑ Dizziness ❑ Limited Movement

❑ Mass/Lump ❑ Memory Loss ❑ Multiple Sclerosis ❑ Visual Disturbance

❑ Other - specify symptom(s):_____

2. When did the symptom(s) begin? _____

3. Where are the symptom(s)? _____

4. Describe your symptoms:_____

❑ Sharp Shooting/Stabbing ❑ Numbness/Tingling ❑ Spasms

❑ Other - Specify Symptom(s):_____

5. How did this begin?

❑ Injury: Specify exact physical location where injury occurred (e.g. home, work, playground, etc.).

_____

How did the injury occur?

❑ Sports: Specify sport and explain injury in detail:_____

❑ Accident/Trauma: Explain the injury in detail:_____

❑ Other: Explain how symptom(s) began:_____

6. Has this injury/symptom been treated before?

❑ No ❑ Unknown ❑ Yes: (Circle One) ***With*** or ***Without*** Surgery?

❑ Without surgery: Explain type of treatment:_____

With surgery:

Type of Surgery? _____

When? _____

Facility? _____

Other related surgeries? _____

7. Additional comments to report/mention to the radiologist? _____

❑ Yes: Additional Comments: _____

❑ No ❑ Unknown

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	**SIGNATURE OF TECHNOLOGIST**	**DATE**	**TIME**