EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

Patient Name ________________________ DOB ___ /___ /___ Date ___ /___ /___ MRN __________

QUESTIONNAIRE: SPINE

Weight: __________ Height: ________________ Gender: Male Female

Are you returning to your referring physician today? Yes No Date of return: ______________________

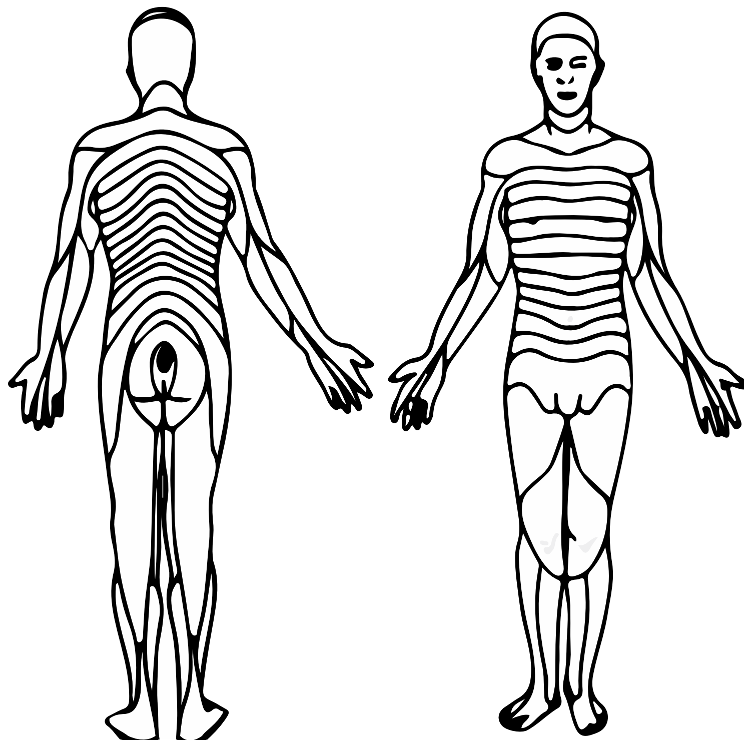
Briefly describe your condition and how long you have had these symptoms. ______________________

Are you had neck or back surgery? Yes No Details/Dates: ______________________

Have you had any of the following performed on your spine? If so, please indicate when, where, and brief results.

TEST	When	Hosp/Imaging Center	Results
X-rays			
CT scan			
MRI scan			
Bone scan			
Steroid Injections			

Please shade in areas of pain, weakness or numbness. Left Right Left Right



Additional comments: ______________________