



Lakemont Medical Center, 7499 Old Hwy. 441 South, Lakemont, GA 30552
Phone: 706-782-0770 Fax: 706-782-1091

SPINE

Name _____ Date _____

Age _____ Weight _____

Area of the spine to be scanned: (Please circle) CERVICAL, THORACIC, LUMBAR

Please give a brief description of your symptoms related to the area to be scanned:

Neck Pain Left ___ Right ___ Arm Pain Left ___ Right ___
Back Pain Left ___ Right ___ Leg Pain Left ___ Right ___
Tingling Left ___ Right ___ Weakness Left ___ Right ___

How long have you had these symptoms?

Was the onset of your symptoms related to an injury?

Was the onset of your symptoms related to work or job?

Any incontinence (loss of bowel or bladder control)?

Do you have any history of cancer? Yes ___ No ___

If yes, what type and when? _____

If yes, have you received radiation therapy? Yes ___ No ___ When _____

Have you had any surgery on your spine? Yes ___ No ___

If yes, indicate what level (if known) _____ When _____

Did the surgery help your symptoms? _____

Prior scans (for the area being scanned today):

CT Yes ___ No ___ When _____ Where _____
MRI Yes ___ No ___ When _____ Where _____
X-ray Yes ___ No ___ When _____ Where _____
Myelograms Yes ___ No ___ When _____ Where _____
Bone Scans Yes ___ No ___ When _____ Where _____

Technologist: _____