

MRI EXTREMITY QUESTIONNAIRE

NAME _____ DATE _____ AGE _____

PLEASE CIRCLE THE APPROPRIATE RESPONSES

1. Have you had surgery?

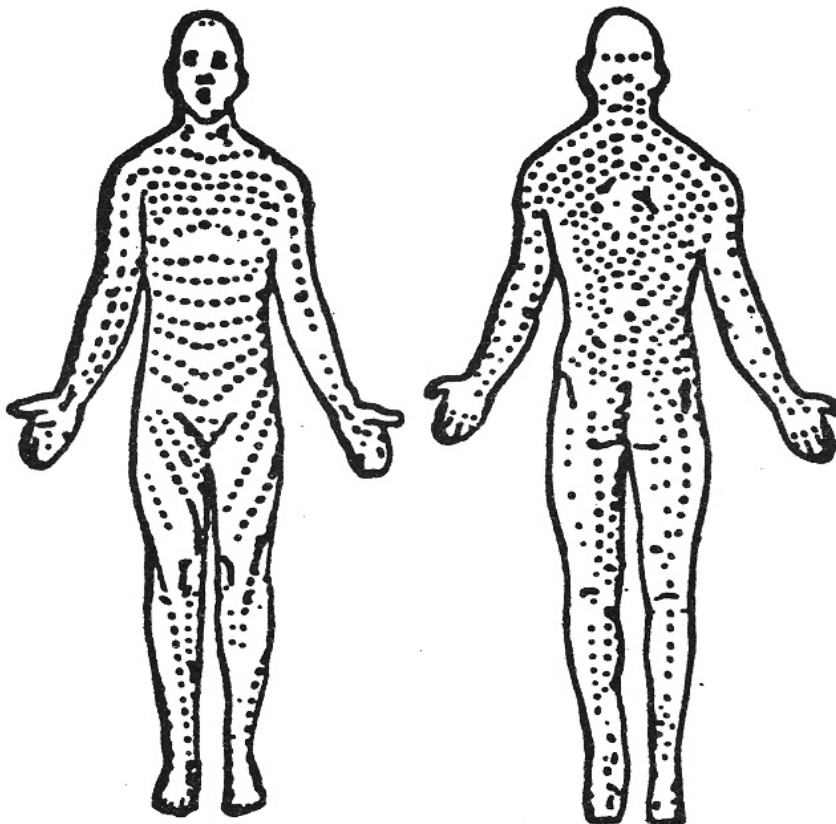
2. Do you have
A. Pain?
B. Numbness, tingling?
C. Weakness

3. Please identify the location of your symptoms in the adjacent diagram.

4. How long have your symptoms been present?

A. Days? C. Months?
B. Weeks? D. Years?

5. Are your symptoms
A. Getting better?
B. Staying the same?
C. Getting worse?



6. Additional comments you would like to make? _____

PATIENT LABEL:

