TRI-CITY RADIOLOGY

SPINE Imaging Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME:_____ **Age:**_____ **Weight:**_____ **Date:** _____

1. What was your chief complaint when you visited your doctor? _____

   _____

   What is the **specific body part** we are imaging (cervical, thoracic, lumbar)? _____

2. Was there an injury? **YES** or **NO** **Date of Injury**: _____
   Where did this occur? (office, school, skating rink, park)? _____
   List the **specific activity** were you doing, when you were injured: _____
   _____

3. Have you **EVER** had this type of injury on the **same body part**? **YES** or **NO**
   If yes, provide specific details of the prior injury (Date, activity, treatment, diagnosis): _____
   _____

4. Do you have **back pain? Yes or No** Do you have **extremity pain**? **YES** or **NO. If yes, where?** _____
   Does the pain go down your **arm**? **Yes** or **No** If yes, **which arm**? _____ **Front or Back**? _____
   Do you have pain radiating down your leg? **Yes** or **NO.** If yes, **which leg?** _____ **Front or Back?**_____
5. Do you have numbness? _____ **YES** or **NO** If yes, where? _____
6. Do you have weakness? _____**YES** or **NO** If yes, where? _____
7. Have you had any loss of control of your bladder or bowels? **YES** or **NO**
8. **Have you ever had surgery on the spinal area that we are imaging today**? **YES** or **NO**
   When (date)? _____ Where (location of surgery)? _____
   What levels of the spine specifically? _____
   What was the short-term (90 days) result of the surgery? _____
   If you had some or complete relief, when did the symptoms return? _____
   Are the symptoms in the same area as before? **YES** or **NO**

Please describe how your problem has changed since the surgery (ies): _____

9. Have you had any other imaging tests done on the area we are imaging today? **YES** or **NO**
   X-rays? _____ When & Where? _____
   CT scan? _____ When & Where? _____
   MRI scan? _____ When & Where? _____
   Bone scan? _____ When & Where? _____

10. Do you have **arthritis?** If yes, do you have **Osteoarthritis** or **Rheumatoid** arthritis? **PLEASE CIRCLE**

11. Do you have a history of **cancer**? If yes, please list:
    a. Type(s) of cancer: _____
    b. Diagnosis date(s): _____
    c. Treatments you have completed for it (radiation, chemotherapy): _____
    _____

12. Do you have any other serious medical conditions that we should know about?

    If yes, please provide details: _____