



NORTH DOVER
R A D I O L O G Y

CERVICAL SPINE QUESTIONNAIRE

Today's Date: _____

Name _____ DOB _____ AGE _____

What complaints or symptoms lead you to see your doctor? _____

How long have you had these symptoms? _____

Have you ever had trauma or injury to your neck? _____ When? _____

If yes, please describe _____

Do you have neck pain? _____ For how long? _____

Do you have pain, numbness or tingling in any of the following areas? Please check where appropriate:

	LEFT	RIGHT
Upper arm	_____	_____
Elbow	_____	_____
Lower arm	_____	_____
Hands/Fingers	_____	_____

Please list any other medical problems that you have, or have had in the past:

_____:

Please list any and all medications you are currently taking:

Patient's Signature _____