

### Trinitas Diagnostic Imaging

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## Thoracic Spine Questionnaire

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If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

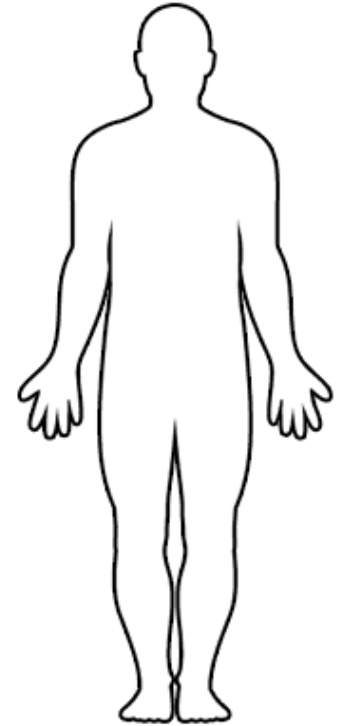
AGE

WEIGHT

DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHAT DO YOU THINK CAUSED THE PROBLEM?



**Please circle the portion of your body that is in pain.**

DO YOU HAVE ANY NUMBNESS, WEAKNESS OR PAIN ?  YES  NO

IF YES, WHERE?

HAVE YOU HAD SPINE SURGERY ?  YES  NO

IF YES, WHEN AND WHAT WAS DONE?

ANY OTHER MEDICAL CONDITIONS?  YES  NO

DESCRIBE YOUR GENERAL HEALTH?

