iCare Diagnostic Imaging, LLC
2781 Freeway Blvd
Suite 160
Brooklyn Center, MN 55430

SHOULDER/ARM MRI QUESTIONNAIRE

PATIENT WEIGHT_________**PATIENT HEIGHT**_________

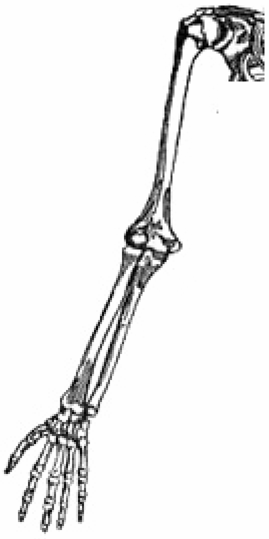
INJURY

Work-related Injury _____ Yes _____ No

Motor Vehicle Accident _____ Yes _____ No

Sports Injury _____ Yes _____ No

Please indicate below where pain is located.



Date of Injury____

Describe Injury____

SYMPTOMS

_____ Pain _____Front of Shoulder _____Front of Arm

_____Back of Shoulder _____Back of Arm

_____Top of Shoulder _____Inside of Arm

_____Outside of Shoulder _____Outside of Arm

_____ Painful clicking sensation______________________________________

_____ Pain with overhead activities___________________________________

_____ Decreased strength____

_____ Decreased range of motion______________________________________

_____ Numbing/burning sensation______________________________________

_____ Mass____

_____ Cortisone/pain injections_______________________________________

How long have you had the above symptoms?_____________________________

_____ History of medical disease (Parkinson's Disease, Arthritis, etc.)

Please describe____

_____ History of cancer (please indicate primary cancer)

Please describe____

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM

X-Rays	Yes	No	Where_____________	Date__________
CT Scan	Yes	No	Where_____________	Date__________
MRI Scan	Yes	No	Where_____________	Date__________
Arthrogram	Yes	No	Where_____________	Date__________
Surgery/Arthroscopy				
	Yes	No	Where_____________	Date__________

What was done? (please specify)____

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Technologist Use: **Technologist** _________________________ **Date** _______________

Contrast: ___________cc of ____________________ (type) injected into _____________________ (area).

Notes/Complications

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