

# MRI/CT Intake Form

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**Name** \_\_\_\_\_

**Date Of Birth** \_\_\_\_\_

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**I am here today for a MRI / CT exam (please circle one).**

Is this a result of an injury? Y N Motor Vehicle Accident? Y N

If Yes, please provide details (including the date) of your injury or accident. \_\_\_\_\_

Is this the first time you are being imaged for this injury/condition? Y N

Have you ever been diagnosed with osteoporosis? Y N UNSURE

If you are experiencing pain, please enter the level of pain occurring for the body part we are imaging.

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No pain	Mild pain			Moderate pain		Severe pain		Worst pain possible	
1	2	3	4	5	6	7	8	9	10

Technologist notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_