BACK IN CARE CHIROPRACTIC

Ivanhoe Chiropractic Centre
73 Livingstone Street Ivanhoe 3079
☎ 9499 4921

Spring St Chiropractic Centre
287 Spring Street Melbourne 3000
☎ 9663 9313

www.BackInCare.com.au

MEMBER CHIROPRACTORS' ASSOCIATION

CONFIDENTIAL CASE HISTORY

Name _____

Address _____

_____ Postcode _____

Telephone _____ Work _____

Mobile _____

Email _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

FOR FEMALES ONLY

Are you pregnant? _____ Date of last period _____

Are you taking a birth control pill? ☐ Yes ☐ No

Occupation _____

Employer name, address & telephone _____

_____

Are you a member of a private health fund? ☐ Yes ☐ No

Name of fund _____ Does it cover Chiropractic care? ☐ Yes ☐ No

Who or what referred you to this clinic? _____

Reason for consulting this clinic (please tick)

☐ I have a specific problem and I require help only with this problem.

☐ After my specific problem has been relieved, I am interested in ways to ensure that the problem does not return.

☐ I feel well and have no symptoms. I am interested in strategies to maintain my good health.

Previous Health History (since birth)

Please list all surgery/operations _____

Please list all accidents/trauma _____

Please list all diseases/illnesses _____

Do you have subluxation (spinal misalignment)? ☐ Yes ☐ No ☐ Unsure

Major Complaint

What is your major symptom or complaint?

_____

_____

When did your symptoms begin?

_____

What caused your symptoms? ☐ Accident ☐ Fall ☐ Trauma ☐ illness ☐ Stress ☐ Job ☐ Other

Have you had a similar complaint before? ☐ Yes ☐ No If yes, when?

_____

Have your symptoms ☐ worsened ☐ stayed the same ☐ improved

What makes your symptoms better? _____

worse? _____

Who have you consulted about your condition?

☐ MD ☐ Chiropractor ☐ Specialist ☐ Physio ☐ Other ☐ None

Are you on any medication? ☐ Yes ☐ No

If so, please list medication _____

Is there a family history of ☐ similar complaint ☐ Heart Disease ☐ Cancer

☐ Arthritis ☐ Diabetes

Is your bed comfortable? ☐ Yes ☐ No Age of mattress?

_____

Sleeping position ☐ back ☐ side ☐ stomach

How many pillows do you sleep with?

_____

Have you seen a Chiropractor before? ☐ Yes ☐ No

If Yes, name and address of Chiropractor _____

Reason for treatment _____

Number of treatments _____ How often? _____ Results of treatment _____

Were X-rays taken _____ When? _____

Many health problems can be related to the spine as the spinal cord controls all body functions. Could you please tick the following symptoms as they apply to you:

☐ Headache	☐ Sinus	☐ Arthritis
☐ Migraine	☐ Tension	☐ Low back
☐ Neck pain & stiffness	☐ Loss of energy	☐ Kidney / bladder problems
☐ Dizziness	☐ Asthma	☐ Diabetes
☐ Depression / nervousness	☐ Numbness / tingling	☐ Female problems
☐ Sleeping problems	☐ Heart problems	☐ Low / high blood pressure
☐ Light headed	☐ Chest pain	☐ Poor circulation/leg cramps
☐ Ears ringing	☐ Indigestion	☐ Hay fever
☐ Loss of balance	☐ Constipation	☐ Diarrhoea
☐ Faint	☐ Heartburn	☐ Hip pain

Signature _____ Date _____

Thank you for your time