Back In Care
CHIROPRACTOR

MEMBER CHIROPRACTORS' ASSOCIATION

Dr. Ron ZUKERMAN
B.App.Sc (Chiropractic)

287 Spring Street Melbourne 3000
Phone: 9663 9313
www.BackInCare.com.au

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

Signature _____ Date _____

Thank you for your time.