

Confidential Case History – Back In Line Chiropractic

Full name: _____ Date: _____

Home address: _____ Suburb: _____ PC: _____

D.O.B: _____ Mobile: _____ Home/Work: _____

Email: _____ Employer: _____ Occupation: _____

Partner's name: _____ Marital status: _____ Height: _____ Weight: _____

Children: (names & ages) _____

Your Medical Doctor & location: _____

Who can we thank for referring you to us? _____

Or how did you hear about us? _____

Is this is a Workcover, TAC, or DVA case? _____

Do you hold a valid healthcare, pension or student card? _____

What is your main reason for today's visit? Specific Concern Wellness Visit/ Checkup

What are your main problems? _____

Over how long has this developed? _____

Caused/aggravated by: _____ It's: Sharp Dull Constant Intermittent

It's interfering with: Work Sleep Routine Other Is it worse at any time of day? _____

Is this getting progressively worse? Yes No What reduces your pain? _____

Have you had similar problems before? Yes No When? _____

Previous treatment by: _____ Result? _____

Previous Chiropractic care? (Name/Place/Year) _____

Family history of these problems? Yes No Spinal x-rays ever? Yes (year) _____

Sleep on: Side Back Stomach? No. of pillows & type? _____

Is your mattress: Soft Firm How old is it (years)? _____

Other health concerns / problems? (past or present) _____

Car accident/s (when?) _____

Injuries, accidents, falls, jolts (when?) _____

Exercise program / sporting activities: _____

Orthotics / supports for back or feet? _____

Previous surgery? _____

Medication, vitamins etc. _____

Notes:

Please take the time to tick the appropriate boxes below

Past	Recent		Past	Recent		Past	Recent	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart troubles
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chronic tension	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder stiffness/tension	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Pain in shoulder blades	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ribs or chest	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol problems
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Scalp Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Low back weakness	<input type="checkbox"/>	<input type="checkbox"/>	Skin troubles
<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	Low back stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Hip pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Buttock pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Knee trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders / ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Stomach tension/pains	<input type="checkbox"/>	<input type="checkbox"/>	Foot or ankle trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Heel / arch pain			
<input type="checkbox"/>	<input type="checkbox"/>	Nausea &/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Painful / clicking jaw			Smoker _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Allergies / hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Arm / elbow Pain			Alcohol _____/week
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Loss of grip			Caffeine drinks _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Wrist or hand pain			Fruit serves _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Unformed stools	<input type="checkbox"/>	<input type="checkbox"/>	Loss of arm power			Vegetables _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles hands / feet			Meat(Vegetarian) _____/week
<input type="checkbox"/>	<input type="checkbox"/>	Urinary disorders	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or blackouts			Fish serves _____/week
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (TIA)			Water volume _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Lost control of bowel/bladder	<input type="checkbox"/>	<input type="checkbox"/>	Knocked unconscious			Skipped meals _____/day
<input type="checkbox"/>	<input type="checkbox"/>	Loss of sexual potency	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			Stress _____/10
<input type="checkbox"/>	<input type="checkbox"/>	Sexual disorders	<input type="checkbox"/>	<input type="checkbox"/>	Light-headed			
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss/gain	FEMALES					
<input type="checkbox"/>	<input type="checkbox"/>	Pain coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual symptoms/pain			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds & flu	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle			
<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant (____ of times)			



Please DO NOT sign below before discussing, with your practitioner, the unusual but potential risks associated with Chiropractic care. You will have a thorough history and examination performed before undergoing any care. There is a 1 in 5 million chance of a stroke occurring as a result of a neck adjustment. There is a one in 30,000 chance of an injury to a disc in your lower back as a result of back adjustments. There is also the possibility of sprains, strains and fractures as a result of Chiropractic care. I am comfortable in having Chiropractic care even though I understand the risks involved.

Patient Signature: _____ Date: _____ Chiropractor: _____