ABOUT BACKCARE
'Caring for your health naturally'

130 Male Street, Brighton, VIC, 3186
Ph: (03) 9592 3319
Fax: (03) 9593 1876
Email: info@aboutbackcare.com.au
www.aboutbackcare.com.au

CONFIDENTIAL QUESTIONNAIRE

Your Details

CONFIDENTIAL *– YOUR INFORMATION IS USED ONLY BY US AND RADIOLOGIST TO HELP GET THE BEST MRI RESULTS*

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

WORK PHONE: _____ HOME PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

BIRTHDATE: _____ OCCUPATION: _____

HEIGHT : _____ WEIGHT: _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

Who is your usual medical doctor (GP)? _____ Suburb/Town_____

How did you find out about our services? _____

Have you ever had an MRI scan before?

Yes ☐ When & why? _____

No ☐

Safety Check

Please tick, if you have any of the following ***(If you are unsure, do not hesitate to ask)***

- ☐ Cochlear implant or Neurostimulator
- ☐ An inserted pump device
- ☐ A programmable, magnetically adjustable ventriculoperitoneal shunt
- ☐ Pacemaker or Defibrillator
- ☐ Any tattoos
- ☐ Any Piercings
- ☐ Had surgery in the past 6 weeks

If you checked any of the above, please elaborate: _____

_____

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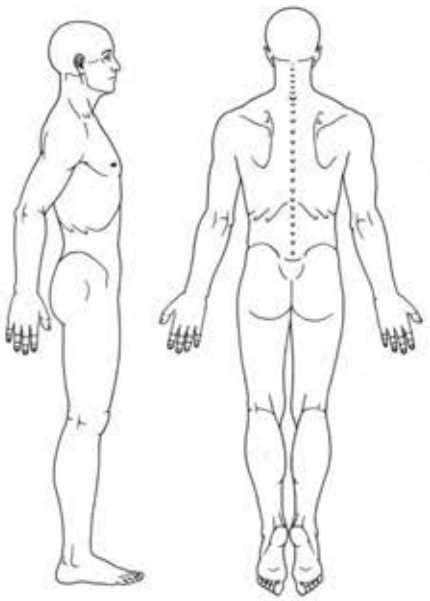
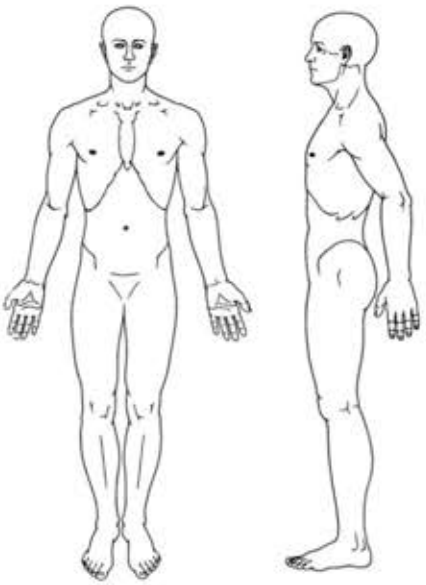
Where is the Problem?

Please click/mark on the diagrams below any areas of discomfort or concern.





Financial

I understand that this office does not hold accounts. In the event that there is an unpaid account, I will be liable for any administration costs charged to me. I agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Your Name: _____ Your signature: _____ Date: _____

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Your Particular Health Problem

Please let us know the reason that an MRI is being requested.
Describe your *main* problem or symptoms: _____

_____

When and how did it start? (date started or approximate duration) _____

Was there any of the following prior to or during the onset? (please circle)

- Illness / infection
- Trauma
- Other significant event

Is your problem? (please tick) getting worse ☐ not changing ☐ improving ☐

Is the pain? (please tick) Constantly there ☐ Intermittent - on and off ☐

What makes your symptoms worse? _____

What relieves your symptoms? _____

Are your symptoms worse at night or any specific time of the day? _____

Do you get pain traveling down into your arms or legs? Yes / No If yes, please describe _____

_____

Does your current problem involve any of the following? If yes, where?

Tingling in either arm or leg Yes / No _____

Numbness in either arm or leg Yes / No _____

Weakness in either arm or leg Yes / No _____

'Weird' sensations in either arm or leg Yes / No _____

Have you seen anyone else for this current condition? (If yes, please list their names) Yes / No _____

_____

Have you ever had this problem before? Yes / No If yes, please describe, including how often _____

_____

Are you currently taking *any* medication, substances, vitamins, supplements, herbs? Yes / No

Please list all: Name Reason

_____

_____

Your Name: _____ Your signature: _____ Date: _____

THANK YOU for taking the time to complete this important questionnaire to help us help you.

Please send the completed form back to us. You may do so via email to info@aboutbackcare.com.au or via fax to (03) 9593 1876