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# 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)**

- |   |  |
|---|--|
| <input type="checkbox"/> Cochlear implant or Neurostimulator                                | <input type="checkbox"/> Pacemaker or Defibrillator      |
| <input type="checkbox"/> An inserted pump device  | <input type="checkbox"/> Any tattoos                     |
| <input type="checkbox"/> A programmable, magnetically adjustable ventriculoperitoneal shunt | <input type="checkbox"/> Any Piercings                   |
|   | <input type="checkbox"/> Had surgery in the past 6 weeks |

If you checked any of the above, please elaborate: \_\_\_\_\_

\_\_\_\_\_



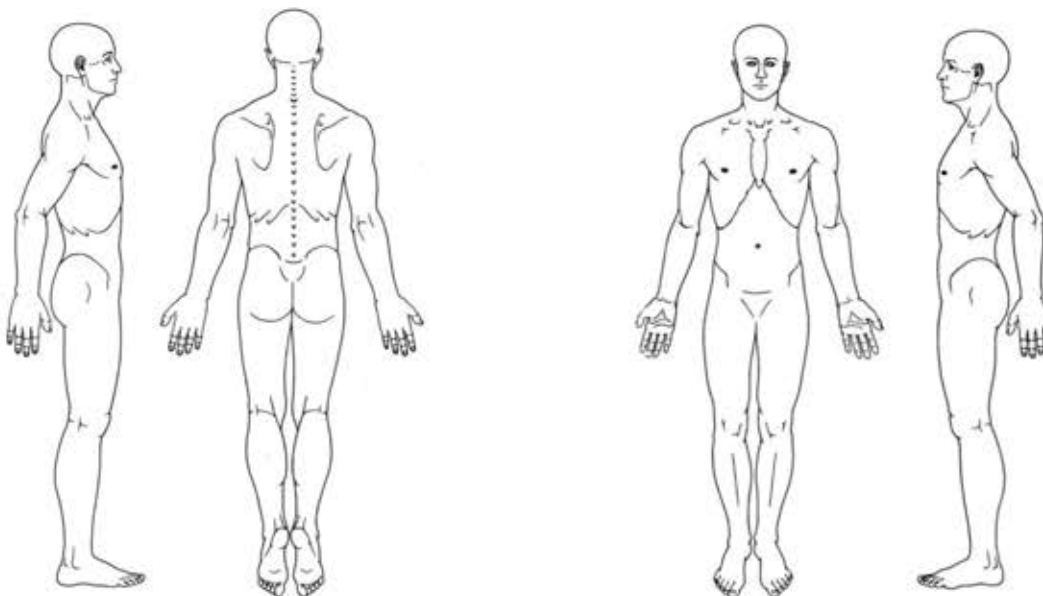
**ABOUT BACKCARE**  
 'Caring for your health naturally'

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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: \_\_\_\_\_



## 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.