date	/ /	title	Mrs Miss Ms Mr Mast Dr
family name		given name	
address			
date of birth		email	
phone	h	w	m
medicare number		exp	

Medicare Reference Number (Small Number in front of your name) _____

SMS message reminder: Yes / No

Dept. Of Veteran Affairs No: Exp: ____/____/____ Gold Card / White Card

Do you require transport to be organized by us for all appointments? Yes / No

Health Care Card / Pension No: _____ Exp: / /

Are you a member of a Private Health Fund: Yes / No

Health Fund: _____ Membership No: _____

Level of Cover (Please tick): ☐ Full Private Hospital ☐ Extras Only

Have you served the 12 month waiting period Yes / No

Account Payment Details

☐ Self

☐ WorkCover Claim No:

Company/Employer:

☐ Other. Details:

Referral Details

Referring Doctor's Name :

Address :

Usual GP (If different to referring doctor)

Address :

Next of Kin Details

Next of Kin : (Relationship)

Address :

Phone :

Patient Consent

I give permission for you to disclose to any doctor, health authority, allied health provider, rehabilitation provider, WorkCover Insurer and it's agents, or other insurer any information about my medical history relevant to my treatment.

Signature: Date:

X-RAYS

QCOS Spine does not store x-rays / scans for any period of time exceeding twelve months. It is essential that you keep the scans in your possession at all times.

I hereby understand that QCOS Spine will destroy any x-rays or scans left in their possession after twelve months, without prior notice.

Signature: Date:

Patient Health Questionnaire

Patient Name : DOB :

Do you currently smoke Yes / No Are you an ex smoker Yes / No

1. Do you have a history of:

		Please specify
Deep Vein Thrombosis (DVT)	Yes / No	
Pulmonary Embolism (PE)	Yes / No	
Blood Clotting Disorders	Yes / No	
Do you have a family history of DVT or PE	Yes / No	
Arthritis (Osteo, Rheumatoid, Gout etc)	Yes / No	

2. Please list any current or previous medical problems.

1.

2.

3.

4.

3. Have you ever had any previous operations? Yes / No

OPERATION	WHEN (YEAR)	DOCTOR

4. Are you taking any of the following medications? If yes, please discuss with your doctor.

Plavix, Clopidogrel, Warfarin, Aspirin, Cartia	Yes / No
Hormone Replacement	Yes / No
Oral Contraceptives	Yes / No

5. Please list all other medications.

MEDICATION eg. Panadol	DOSE eg. 1 gram	FREQUENCY eg. 4 per day	ROUTE eg. capsule

6. Please list any allergies

MEDICATION / SUBSTANCE	REACTION

7. Have you had any previous back/neck complaints

1.

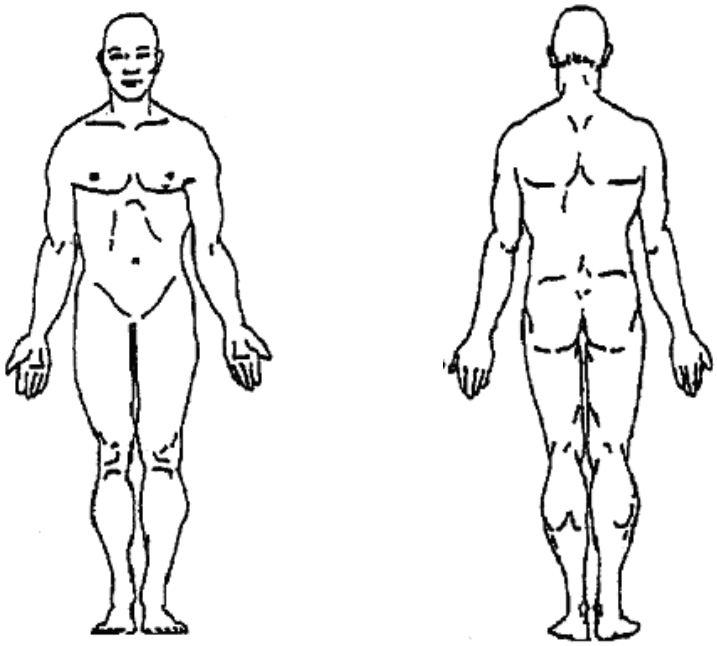
2.

Patient Name : DOB :

Do you have a current legal claim regarding this condition?	Yes	/	No
Are you seeing a Solicitor for this condition?	Yes	/	No
Will you need a legal report?	Yes	/	No

Please indicate on this diagram where your pain is located

Mark areas of pain using shading.
Mark areas of tingling or pins and needles with crosses.



Please mark your current level of back pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Please mark your current level of leg pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Patient Name : DOB :

This questionnaire has been designed to give the doctor information about how your neck pain has affected your ability to manage in everyday life. Please answer each section and mark only one box per section that applies best to you. We realise that you may consider that two of the statements may apply to you, but please only mark the box that best describes your problem.

Back Pain Questionnaire

Pain Intensity

- ☐ I can tolerate the pain without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief of pain
- ☐ Pain killers give partial relief of pain
- ☐ Pain killers give very little relief of pain
- ☐ Pain killers have no effect on pain and I do not use them

Personal Care

- ☐ I can look after myself normally without extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of personal care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Lifiting

- ☐ I can lift heavy objects without extra pain
- ☐ I can lift heavy objects but it gives extra pain
- ☐ I can only lift heavy objects if they are on a table
- ☐ I can only lift light / medium objects if they are on a table
- ☐ I can only lift very light objects
- ☐ I cannot lift anything due to pain

Walking

- ☐ I can run or walk without pain
- ☐ I can walk comfortably but running is painful
- ☐ Pain prevents me from walking more than one hour
- ☐ Pain prevents me from walking more than 30 minutes
- ☐ Pain prevents me from walking more than 10 minutes
- ☐ I cannot walk more than a few steps at a time

Sitting

- ☐ I can sit in any chair as long as I want
- ☐ I can only sit in a special chair as long as I want
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Standing

- ☐ I can stand as long as I want
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing more than one hour
- ☐ Pain prevents me from standing more than 30 minutes
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Sleeping

- ☐ I sleep well
- ☐ Pain occasionally interrupts my sleep
- ☐ Pain interrupts my sleep half of the time
- ☐ Pain often interrupts my sleep
- ☐ Pain always interrupts my sleep
- ☐ I never sleep well

Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but gives me extra pain
- ☐ Pain restricts more energetic social activities
- ☐ Pain has restricted my social life and I go out less often
- ☐ Pain has restricted my social life to home
- ☐ I have no social life because of pain

Travelling

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it causes some pain
- ☐ Pain is bad but I manage to travel over two hours
- ☐ Pain restricts me to trips of less than one hour
- ☐ Pain restricts me to trips of less than 30 minutes
- ☐ Pain prevents me from travelling except to the doctor

Employment / Housekeeping

- ☐ My normal homemaking/ job activities don't cause pain
- ☐ I can perform all these activities but do experience pain
- ☐ I can perform most activities but do experience pain
- ☐ Pain prevents me from doing anything but light duties
- ☐ Pain prevents me from doing even light duties
- ☐ Pain prevents me performing any job/ activities at all

Patient Name : DOB :

Height (cm) Weight (kg)

What date did the injury occur?

How did the injury occur?

Have you had any previous treatment with regards to this injury? Eg: Physiotherapy, Chiropractic, Occupational Therapy, Psychology, Injections, Pain Medication, Acupuncture etc.

If you have had any of the above treatment, when did it commence and how often have you been having treatment?

Have you seen any other Specialists with regards to this injury? Yes / No

If yes, what is the name of your specialist/specialists:

Have you had any x-rays, CT scans or MRI's taken with regards to this injury? Yes / No

If yes, please list the tests you have had:

Are you currently working? Yes / No

If no, how long have you been off work?

Patient Name : DOB :

WorkCover Patients Only

WorkCover Claim No:

WorkCover Claim Manager: Ph:

Employer Name:

Employer Phone No:

Before this accident, did you have any condition or injury that affected this part of your body? Yes / No

Have you ever had any previous WorkCover claims? Yes / No

Important Information

It is very important that your WorkCover Medical Certificates are kept up to date at all times. Please request a new certificate from your doctor at each appointment, if required.

Your consultations will only be paid by WorkCover if they hold a current Medical Certificate.

It is the patient's responsibility to give a copy of the Medical Certificate to WorkCover and the Employer. This certificate is also to be given to anyone that is providing treatment eg: Physiotherapist, Chiropractic, Occupational Therapist, Hand Therapist etc

A current referral must be held by our office at all times.

Medical Certificates will not be issued over the phone.

Signature: Date: