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.

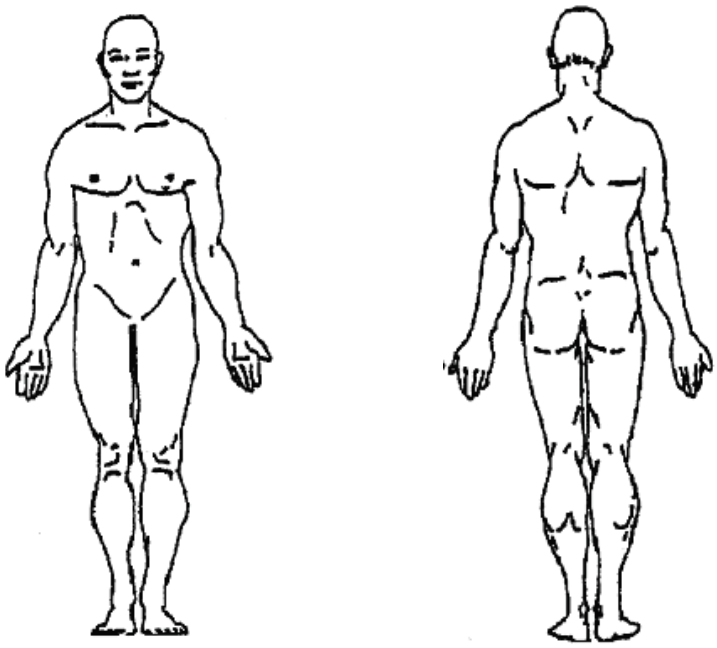
2.

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 neck 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 arm 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.

Neck Pain Questionnaire

Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is worst imaginable at the moment

Concentration

- ☐ I can concentrate fully with no difficulty
- ☐ I can concentrate fully but with slight difficulty
- ☐ I have a mild degree of difficulty in concentrating
- ☐ I have a moderate degree of difficulty in concentrating
- ☐ I have severe difficulty in concentrating
- ☐ I cannot concentrate at all

Personal Care

- ☐ I can look after myself normally without causing 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

Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

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 conveniently positioned
- ☐ I can only lift light/medium objects if they are conveniently positioned
- ☐ I can only lift very light objects
- ☐ I cannot lift or carry anything at all

Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I can't drive my car as long as I want because of moderate pain
- ☐ I can hardly drive at all because of severe neck pain
- ☐ I can't drive my car at all

Reading

- ☐ I can read as long as I wish without pain
- ☐ I can read as long as I wish but it causes slight neck pain
- ☐ I can read as long as I wish but it causes moderate neck pain
- ☐ I can't read as long as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all

Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which occur infrequently
- ☐ I have moderate headaches which occur infrequently
- ☐ I have moderate headaches which occur frequently
- ☐ I have severe headaches which occur frequently
- ☐ I have headaches almost all the time

Recreation

- ☐ I can do all my recreation activities with no neck pain
- ☐ I can do all my recreation activities with some neck pain
- ☐ Pain mildly restricts my usual recreation activities
- ☐ Pain moderately restricts my usual recreation activities
- ☐ I can hardly do any recreation activities because of neck pain
- ☐ I can't do any recreation 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: