PainMedSA
Pain & Rehabilitation Specialists

New Patient Proforma

Once completed, please scan and email to
reception@painmedsa.com

DATE: ____ / ____ / ___

Surname ..... First Name(s) .....

Date of birth _____ / _____ / _____ Title: Mr / Mrs / Miss / Ms / Dr Sex: M / F / Other: .....

Address .....

Suburb ..... Postcode .....

Phone Home: ..... Mobile: .....

Email: .....

Next of Kin ..... Relationship .....

Next of Kin Contact Phone Number .....

Do you consent for PainMedSA staff to discuss your care, appointments etc with your Next of Kin YES **or** NO
Do you consent for PainMedSA staff to SMS your mobile number appointment reminders etc YES **or** NO
All eligible patients are added to our Clinical Trial Database – to opt out of this process please tick here ◯

GP .....

Practice Name .....

Practice Address .....

Contact Details: Phone .....Fax .....

Medicare Number ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ Expiry ..... / .....

Your number on card next to your name (please circle) 1 2 3 4 5 6

Veterans Affairs Number .....Type of card (Gold/White) .....

For DVA white card holders what is the approved injury?.....

Private Hospital cover? Yes ☐ No ☐ Extras only ☐ **Level of Hospital cover** Top ☐ Basic ☐
Note: Extras only and Basic hospital cover does not extend to admission to private hospital.

Name of Private Hospital Fund .....Member number.....

If your injury/pain is work related and you have an open claim – please complete this section

Employer ..... Date of injury _____ / _____ /_____

Employer's address .....

Insurance company .....

Claim no ..... Case Manager 's Name .....

Contact Details: Phone .....Fax .....

If your injury/pain is motor vehicle accident (MVA) related and you have an open claim – please complete this section. Please note MVA consultations must be paid in full on day of consult and you will need to claim back any entitlements from your insurer.

Claim no..... Date of accident _____ /_____ /_____

Insurer ..... Case Manager's Name .....

Lawyer / Solicitor

.....

Lawyer's address

.....Phone.....

Contact Details: Phone….. ……Fax …….

REHAB Provider

Name: ……..

Company ……

Address: :…….

Contact Details: Phone ……Fax ……

Privacy Policy – All Patients

I consent to the health providers of PainMedSA recording and sharing information obtained from me. I understand that this may be shared (verbally and/or in writing) with laboratories, radiological facilities, other health service providers, rehabilitation consultants, insurers, medical defence organisations, lawyers or my employer for the purpose of investigation, treatment and rehabilitation of my injury or illness. I understand that the exchange of information is necessary to limit the chance of misunderstanding and to assist in the management of my condition. I understand that I may revoke this consent at any time in writing.

I further consent to the doctors/practitioners of PainMedSA obtaining medical information from laboratories, radiological facilities, other health service providers, rehabilitation consultants, insurers, lawyers or my employer for the purpose of investigation, treatment and rehabilitation of my injury or illness.

I consent to be fully responsible for any applicable cancellation fees as per PainMedSA's cancellation policy.

Accounts Policy – Private Patients

I acknowledge that I am responsible for the payment of all accounts associated with the treatment of my injury or illness and any costs associated with the recovery of my accounts should they fall into arrears.

I further acknowledge that full payment is expected at the time of consultation.

Work cover, MVA, Compensable Policy – All Third Party Patients

If my injury is part of an accepted claim under RTWSA or SA MVA Third party Claim in full I acknowledge that I have provided all current claim details pertaining to the injury for which I am about to receive treatment. I acknowledge that this is an open claim and that prior approval in writing has been given by my insurer for the services I am about to receive.

I acknowledge that I am responsible for the payment of all accounts associated with the treatment of my injury or illness if the claim is closed, undergoing determination/review or suspended.

Any costs associated with the recovery of my accounts should they fall into arrears as a result of such action (if the claim is closed, undergoing determination/review or suspended) are my responsibility.

I further acknowledge that all accounts will be paid in full at the time of consultation.

MVA ONLY I further acknowledge that the doctor is treating me in the capacity of a private patient and that I (or my agent) will not seek any Medico Legal reports or opinions for my MVA claim. All costs involved in my treatment will be paid by me.

Signature ……..

Name …… Date ____ /____ /_____

Age …… years Relationship status (please tick ✓) Married ☐ Widowed ☐ Defacto ☐ Partner ☐ Single ☐

Children Yes ☐ No ☐ If yes, please list age(s) ……

Please list who lives with you and their ages. ……

……

Occupation / work status

Please list your age and the year when you completed your schooling: Age …… Year ……

Please list your qualifications (including date completed) ……

……

Please list employment history (paid and voluntary)

Employer	Years of service	Work duties performed

Current employer ……Current job title ……

How long have you worked for this employer? ……

Current hours of work ☐ full time ☐ part time ☐ casual ☐ reduced/restricted hours ☐ not working

Please list the physical requirements of your current work duties (ie lifting / driving / sedentary / repetitive movements etc)

……

……

……

Do you currently have physical restrictions for your capacity in place at your place of work? Yes ☐ No ☐

If yes, please describe ……

……

……

How do you travel to and from work? ☐ car ☐ public transport ☐ walk ☐ cycle

How long does your travel to and from work take? ……

History of current injury/pain

Date of injury / incident / pain onset ____ / ____ / _____

What happened?.....

……

……

……

……

……

……

Please list <u>all</u> medications you are currently taking (including those for pain) and indicate (✓) if they're helpful

			Benefit			
Medication	Dose	Side effect	None	Mild	Moderate	Marked

In the last 24 hours how much relief have pain treatments or medication provided? (please circle)

no relief **0% 20% 30% 40% 50% 60% 70% 80% 90% 100%** complete relief

Please list any medication you have taken in the past for your pain and indicate whether or not they were helpful

			Benefit			
Medication	Dose	Side effect	None	Mild	Moderate	Marked

Do you think you need more medication, or stronger medication, than you are currently taking? **(please circle one number**)

agree **1 2 3 4 5** disagree

Medical history

Are you currently being treated for any other medical conditions? If so, what are they, and who is treating you?

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Have you ever had an operation? Yes ☐ No ☐ If yes, please describe (in order of occurrence if possible)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Have you ever been admitted to hospital for any reason aside from an operation? Yes ☐ No ☐

If yes, please describe the reason for admission ……

……

……

……..

Have you ever had a motor vehicle accident in the past? Yes ☐ No ☐ If yes, please list injuries/treatments

……

……

……..

Do you currently smoke? Yes ☐ No ☐

How many/day? …… For how long did you/have you smoked? ……

Do you drink alcohol? Yes ☐ No ☐

If yes, what type? ……..

How many drinks per day? …… How many times/week? ……

Do you consume any recreational drugs? Yes ☐ No ☐

If yes, what are they and how often do you take them?.....

……

……

Are you allergic to any pills, lotions, or agents of any kind? Yes ☐ No ☐

If yes, please list including reaction experienced ……

……

……..

Did you exercise before the current injury/pain problem? Yes ☐ No ☐

Do you currently do any regular exercise? Yes ☐ No ☐

If yes, please describe (ie type, how often) ……

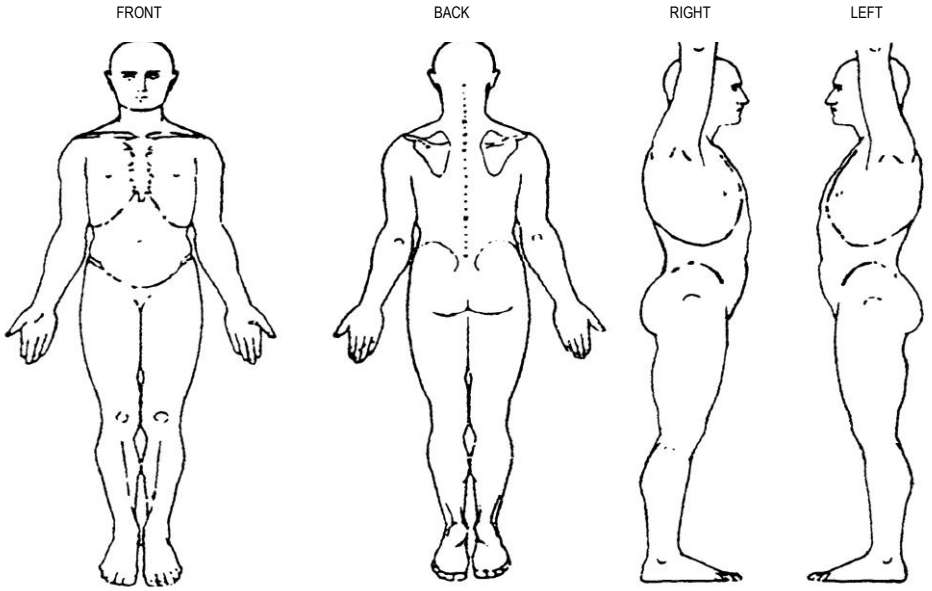
……..

Where is your pain? Please number your sites of pain in order of severity in the table below.

Mark in the most troublesome site **1**,
then next most troublesome site **2** and so on.
Please include all significant sites of pain. If you have total or almost total body pain then you can mark the final option '1' instead of marking each individual site.

_____ head / face / mouth _____ abdominal _____ neck region _____ groin region
_____ shoulders _____ pelvic _____ arm(s) / hand(s) _____ anal/genital
_____ hip region _____ chest _____ legs(s) / feet _____upper back (thoracic)
_____ lower back / buttocks

On the diagram, please shade in the areas where you feel pain. Put an **X** on the area that hurts the most.



Please rate your pain by circling the one number that best describes your pain at its **worst in the last 24 hours**.

no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain imaginable

Please rate your pain by circling the one number that best describes your pain at its least in the **last 24 hours**.

no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain imaginable

Please rate your pain by circling the one number that best describes your pain **on average**.

no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain imaginable

Please rate your pain by circling the one number that tells you how much pain you have **right now**.

no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain imaginable

Please describe the way your main pain feels to you **(please circle one or more).**

burning stinging stabbing shooting aching numbness tingling

other……..

Which statement best describes the typical pattern of your main pain? **Please circle the best option.**

1 always or almost always present, constant intensity
2 always or almost always present, variable intensity
3 recurring irregularly (eg like a headache)
4 recurring regularly (eg premenstrual pain)

What makes your pain **worse** (eg activity, cold weather etc)? ……..
……

What eases your pain (eg pain killers, rest, activity etc)? ……..
……

Please circle the number that describes how during the past 24 hours pain has interfered with your:

general activity

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

mood

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

walking ability

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

normal work (includes outside the home & housework)

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

relations with other people

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

sleep

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

enjoyment of life

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

Many people find that persistent pain interferes with their sexual functioning. Do you find that pain causes interference to you?
Yes ☐ No ☐

If you answered YES, then how much does pain interfere with:

.

your desire for sex

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

your enjoyment of sexual activity

does not interfere	0	1	2	3	4	5	6	7	8	9	10	completely interferes

Please list up to four specific activities that are important to you and that you are unable to do or have difficulty doing as a result of pain (eg brushing hair or hanging washing?) and circle the one number that best describes your current ability to perform them.

1 Activity ……..

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at same level as before pain

2 Activity.....

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at same level as before pain

3 Activity.....

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at same level as before pain

4 Activity.....

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at same level as before pain

Psychological assessment

Please tick (✓) the number that best describes how you felt:

	a little of the time	some of the time	none of the time	most of the time	all of the time
In the last 4 weeks how often did you feel tired for no good reason?					
In the last 4 weeks how often did you feel nervous?					
In the last 4 weeks how often did you feel so nervous that nothing could calm you down?					
In the last 4 weeks how often did you feel hopeless?					
In the last 4 weeks how often did you feel restless or fidgety?					
In the last 4 weeks how often did you feel so restless that you could not sit still?					
In the last 4 weeks how often did you feel depressed?					
In the last 4 weeks how often did you feel that everything was an effort?					
In the last 4 weeks how often did you feel so bad that nothing could cheer you up?					
In the last 4 weeks how often did you feel worthless?					

Healthcare utilisation

How many times in the past 3 months have you seen a general practitioner because of your pain? .....

How many times in the past 3 months have you seen medical specialists (eg orthopaedic surgeon, neurologist etc) because of your pain? ……..

How many times in the past 3 months have you seen health care professionals other than doctors (eg physiotherapist, chiropractor, psychologist) because of your pain?
……

How many times in the past 3 months have you visited a hospital emergency department because of your pain? …….

How many weeks in total over the past 3 months have you been in hospital as a patient because of your pain? ……..

Treatment history

Please describe the initial treatment for your pain/injury …….
……

……..

……

……..

Please list doctors seen for current pain/injury

Name of Specialist	Type of specialty	Approximate date of consultations

Please list operations you have had for your **current** pain / injury

Type of operation	Surgeon	Date

Please tick (✓) if you have had the following investigations for current pain/injury

☐ xrays ☐ CT scan ☐ bone scan ☐ MRI

☐ ultrasound ☐ blood tests ☐ nerve studies

Have you had the following treatment for your current injury/pain? (please tick✓)

	Never tried	Treatment ongoing	Helpful	No help	Made pain worse
surgery					
nerve block					
TENS					
bed rest					
psychology					
hypnosis/relaxation					
acupuncture					
chiropractic					
osteopathy					
physiotherapy					
hydrotherapy					

Please list current treatment provider details (ie physiotherapist, chiropractor etc)

Treatment	Provider name	Provider location	Frequency of treatment