Patient Registration Form

DO YOU GIVE CONSENT FOR YOUR INFORMATION TO BE COPIED TO OTHER MEDICAL SPECIALISTS ASSISTING IN YOUR CARE Y / N

Mr/Mrs/Ms/Miss/Master/Dr/Other: _______

Family Name: ___________________ First Name: __________________ Middle Name: __________________________________

Full Name Of Parent(s) If Patient Under 16: ____

Address: ____ Suburb: ____

Post Code: _____________________ Email: ____

Home Phone: ________________________ Work Phone: ____________________________ Mobile: ______________________________

Gender: ___________ Age: ___________ Date Of Birth: ____________________ Height: _______________ Weight: _______________

BMI:______________ Handedness: _________________

Emergency Contact:

Next of Kin (Full Name) : _______________________________________ Relationship: _____________________________

Mobile: __________________________ Work Phone: ____________________________

Private Health Insurance: Yes No Health Fund Name: __________________ Membership Number: _____________________

Aged/Disability Pension: Yes No Membership Number: _______________________ Expiry: __________________

Medicare Number: ________________________ Position on Card: _________ Expiry: _________________

General Practitioners Name: ____

General Practitioners Address: ____

General Practitioners Telephone Number: ______________________________

Workers Compensation and Compulsory Third Party

(Please note that if you are coming in under WC or CTP you will need to provide approval for your consultation on the day of or before your appointment otherwise you will be charged the full amount and once you receive approval you may claim back through insurance. Sorry for any inconvenience).

Employer Name (if applicable): ____ Date of Injury: __________________

Employers Address: ____ Phone: _________________________

Solicitors Name & Address (if applicable) : ____

Claim Number: ____________________________ Case Manager: ____

Telephone: ____________________________ Fax: _____________________________

Location of injury: _______________________ Date: ____________________________ Type: _________________________

Chief Complaints: Please circle Yes or NO

Neck Pain: Yes No

Shoulder Pain: Yes No

Arm Pain: Yes No

Upper Back Pain: Yes No

Lower Back Pain: Yes No

Hip/Leg Pain: Yes No

Any other complaints: ____

Which area is worse?: ____

How long have you had this problem?: ______________________________

Did your symptoms follow an injury? Yes No

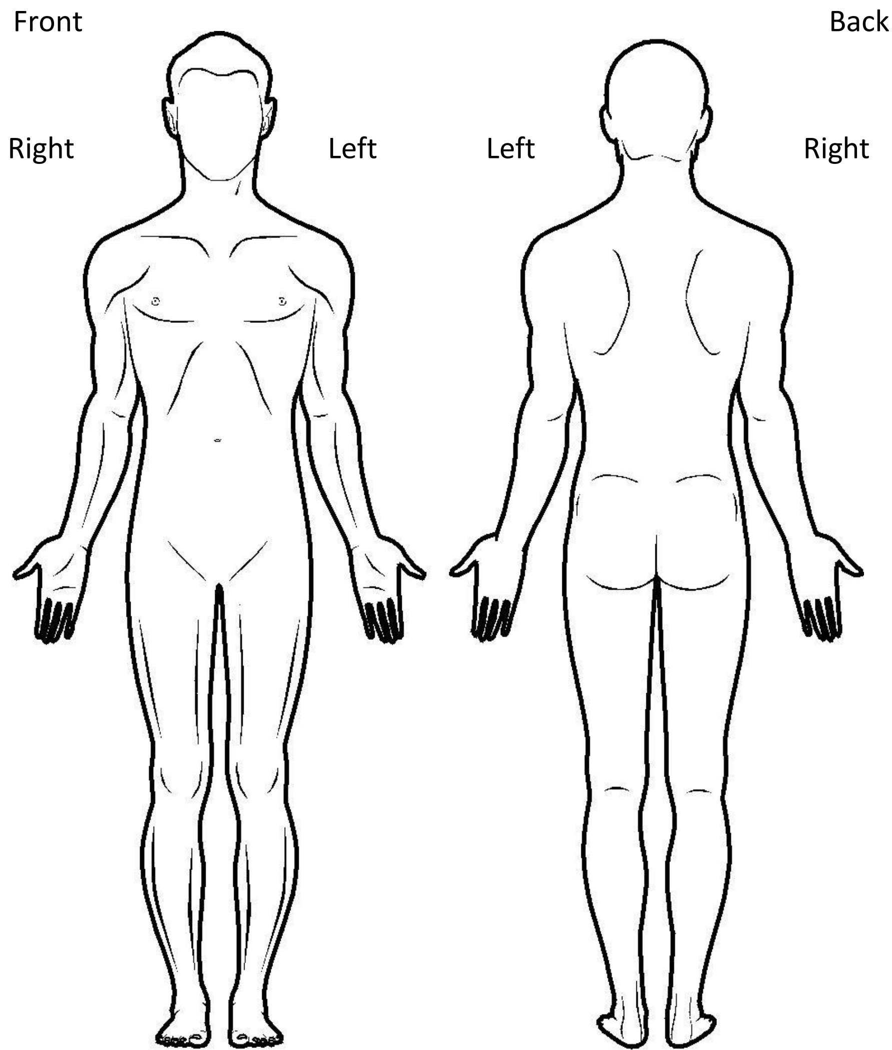
If yes At Work Auto Accident Other

Please describe what happened: __________________________________

____

Place correct markings indicating your pain.

Pain: XXXX **Numbness: OOOO**



Circle your pain levels over the past two weeks:

Back Pain:

(None) 1—2—3—4—5—6—7—8—9—10

Leg Pain:

(None) 1—2—3—4—5—6—7—8—9—10

Neck Pain:

(None) 1—2—3—4—5—6—7—8—9—10

Arm Pain:

(None) 1—2—3—4—5—6—7—8—9—10

Describe your pain (Circle ALL that applies to you)

Constant	Deep	Dull	Sharp	Intermittent	Throbbing
Stiffness	Aching	Shooting	Cramp	Burning	Stabbing

When is your pain at its worst:

Walking Standing Sitting Lying Down

What relieves it:

Walking Standing Sitting Lying Down

Previous Treatment (Circle if you have had this treatment then indicate if it was better, worse or made no change) :

Physiotherapy:	Better	Worse	No Change	Massage:	Better	Worse	No Change
Medication:	Better	Worse	No Change	Acupuncture:	Better	Worse	No Change
Chiropractic Adjustment:	Better	Worse	No Change	Spine Injections:	Better	Worse	No Change
Bed rest:	Better	Worse	No Change	Pool Therapy:	Better	Worse	No Change

IF you have had previous spinal surgery, what were your symptoms before the surgery? Please describe:

____
____
____

Did your symptoms improve after surgery? _____________________ If yes how long afterwards? ______________________________

Did your symptoms get worse after surgery ? __________________ If yes explain: ____

Have you been released back to work after surgery ? ___________________ If yes when ? _____________________________________

Medical History: If you have ever had (circle all that apply)

Asthma/Breathing difficulties	Phlebitis or blood clots	Cancer
Strokes	Radiation/Chemotherapy	Thyroid trouble(s)
Migraine/Other Severe Headaches	Kidney Infections	High Blood Pressure
Heart Attack	AIDS/HIV	Diabetes
Kidney Stone	Fibromyalgia	Arthritis
Stomach Ulcers	Seizures	Tuberculosis
Hepatitis		

Other: ____

____

Previous Investigations:

Please list the dates you have had the following Radiology studies:

MRI: ___________________________________ Bone Mineral Density Scan: ____________________________

CT Scan: ________________________________ EMG/Nerve Conduction Studies: _________________________

X-rays: _________________________________ Bone Scan: ______________________________________

Medication Allergies:

Name Of Medication	Type Of Reaction	Date (If known)

Current Medications:

Please list the medications you currently take including prescription, non-prescription, vitamins and supplements

	Name	Dose	Frequency		Name	Dose	Frequency
1.				8.			
2.				9.			
3.				10.			
4.				11.			
5.				12.			
6.				13.			
7.				14.			

Family History:

Does anyone in your family **apart from you** suffer from any of the following conditions? Please circle **and** describe those that apply to you:

Spinal Problems Please Describe: ____

Bleeding Disorders Please Describe: ____

Heart Disease Please Describe: ____

Cancer Please Describe: ____

Diabetes Please Describe: ____

Social History:

Marital Status: Single Married De Facto Divorced Widowed Separated

Number of children (if any): _________ Age(s): ______________________________

Who Lives with you at home?: ____

Work status: Working Not Working Homemaker Student Disabled Retired

Primary occupation (Or previous if not currently working/retired): ____

Have you ever/ do you currently use tobacco? If yes how many a day: _________ Years Smoking: ______________

Date ceased: ___________________________

Amount of alcohol consumed in a typical week: ____

Do you use recreational drugs? ____

Do you participate in regular exercise? (If yes please describe) ____

____