Name: _____ Date of Birth: _____ **Office use**

File No: _____

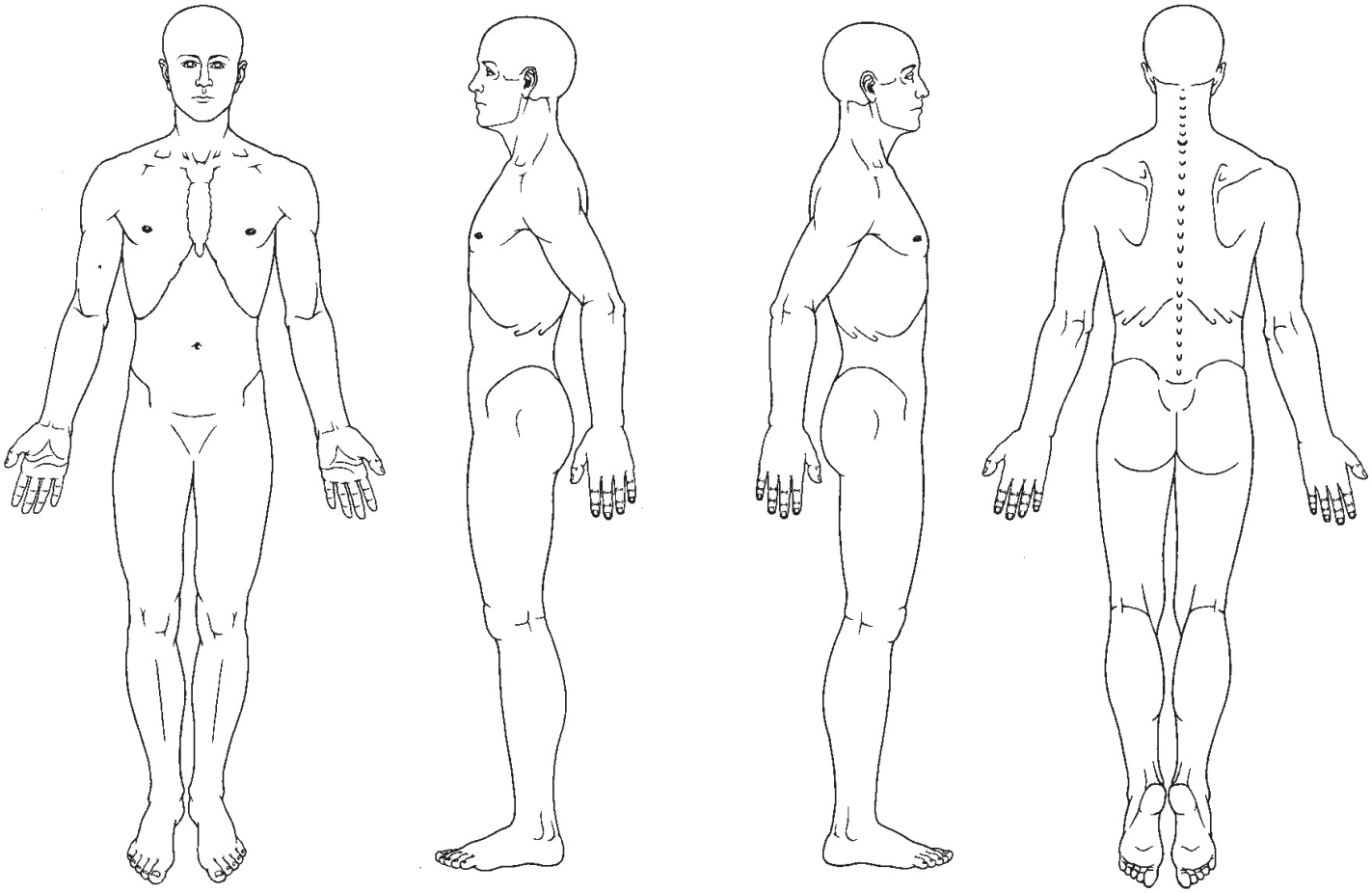
Practitioner: _____

mobile phone number: _____

email address: _____

We ask patients to complete this form when they come to us with a new problem. This information helps us make an accurate diagnosis, and completing it in advance saves time during your visit which may be better used for more examination or treatment. You will have time to discuss any points from this form that you or your practitioner feel need further explaining.

Please mark your areas you feel pain or other symptoms on these diagrams:



CareResponse

Information about your condition

How long is it since you had a ***whole month*** without this pain?

More than 10 years _____ **Yes / No**
6 - 10 years _____ **Yes / No**
3 - 5 years _____ **Yes / No**
1 - 2 years _____ **Yes / No**
7 - 12 months _____ **Yes / No**
3 - 6 months _____ **Yes / No**
Less than 3 months _____ Y**es / No**

How many days is it since you had a whole month without this pain **_____days**

Have you **ever** had this problem before? **Yes / No**

In total, have you had this pain for **more** than 30 days in the last year **Yes / No**

Think about the problem you are hoping that treatment can help you with and how it affects you. Then type in the symptom which is the most important to you - for example, 'sore neck' Use any words you like to describe the symptom. It must be a single symptom - for example if you have a sore neck and tingling down the arm, these count as two symptoms and you should only enter one of them in this space. Click on a score to indicate how bad it has been **over the last week** on a scale of 0 to 6, with **0** being **'as good as it can be'** and **6** being as **'bad as it can be'**.

Symptom 1 (required) _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

If you have another symptom (physical or mental) which you feel is associated with the same problem, please enter this – for example 'tingling down arm' or 'difficulty sleeping comfortably'. You don't have to enter a second symptom if you don't feel it's relevant, but if you have entered one, click on a score to indicate how bad it has been over the last week.

Symptom 2 (optional) _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

Please enter an activity of daily living (physical, mental or social) which your symptom/s prevent or interfere with – for example 'getting dressed' or 'concentrating at work' or 'visiting friends'. Choose something that is important to you in your everyday life and that you were able to do without much trouble until this current problem started. Again, this question is optional but if you have answered it click on a score in the range from 0 to 6 where 0 is 'as good as it can be' and 6 being 'as bad as it can be'.

Activity (optional) _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

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Finally, please enter a score to indicate your general wellbeing i.e. how you feel in yourself. This question must be completed - without it the form is incomplete and cannot be used.

Symptom 2 (optional) _____

as good as it can be **0 1 2 3 4 5 6** *as bad as it can be*

Are you taking medication **for this problem** **Yes / No**

Pre-Examination medical history information
As part of your first visit you will be able to discuss your problem as well as any other medical issues that may be significant. In order to use the time to the best advantage can we ask you to answer these background medical questions now.

Do you have, or have you ever had, treatment for:

Problems with circulation, blood pressure or your heart _____ **Yes / No**
Arthritis or orthopaedic problems _____ **Yes / No**
Lung or breathing problems _____ **Yes / No**
Digestive problems _____ **Yes / No**
Kidney or bladder problems _____ **Yes / No**
Epilepsy or neurological problems _____ **Yes / No**
Anxiety, depression, stress or psychological problems _____ **Yes / No**
Allergies _____ **Yes / No**
Cancer or tumours _____ **Yes / No**
Diabetes _____ **Yes / No**
Are you currently taking any medication including contraception? _____ **Yes / No**
Have you had any operations to date? _____ **Yes / No**
Do you smoke? _____ **Yes / No**
Do you drink alcohol? _____ **Yes / No**
Have you suffered any significant injury as a result of an accident? _____ **Yes / No**

Please use this space to provide more information about your answers or anything you feel may be helpful for us to know:

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Continued from page three

Back Condition Information *Only complete this section within the grey box if your problem includes pain in your lower back or buttocks,*

For this set of questions, please think about your back pain over the past two weeks.

Overall, how **bothersome** has your back pain been in the **last 2 weeks?**

Not at all **Slightly** **Moderately** **Very much** **Extremely**

For each of the following, please indicate whether you agree or disagree with the statement, thinking about the last 2 weeks.

My back pain has **spread down my leg(s)** at some time in the last 2 weeks	**Agree / Disagree**
I have pain in the **shoulder or neck** at some time in the last 2 weeks	**Agree / Disagree**
I have only walked **short distances** because of my back pain	**Agree / Disagree**
In the last 2 weeks, **I have dressed more slowly** because of my back pain	**Agree / Disagree**
It's not safe for a person with a condition like mine to be physically active	**Agree / Disagree**
Worrying thoughts have been going through my mind a lot of the time	**Agree / Disagree**
I feel that **my back pain is terrible** and **it's never going to get any better**	**Agree / Disagree**
In general I have **not enjoyed** all the things I used to enjoy	**Agree / Disagree**