

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Office use

File No: \_\_\_\_\_

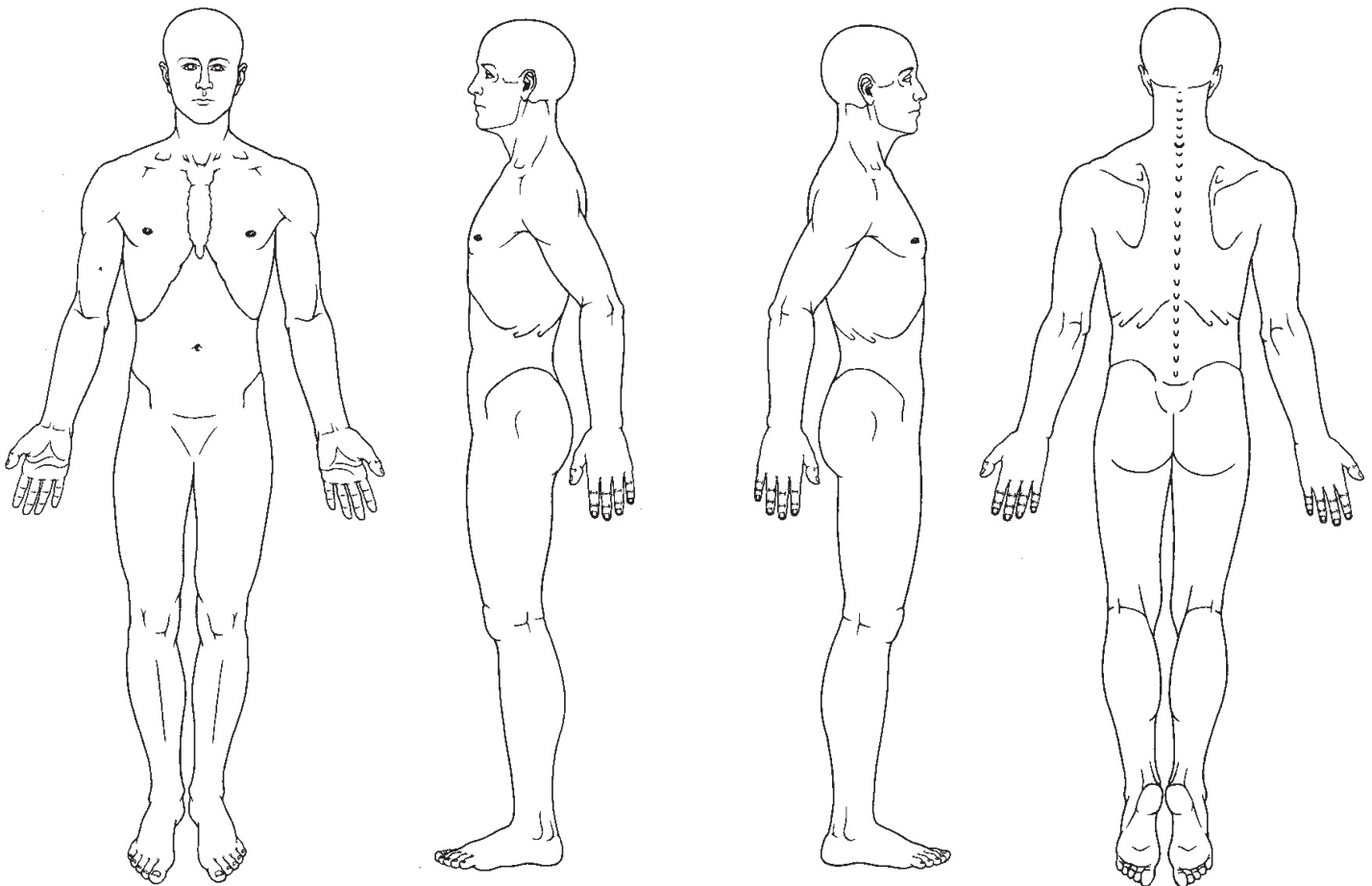
Practitioner: \_\_\_\_\_

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:**



## 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 \_\_\_\_\_ Yes / 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

## 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:**

**Back Condition Information**

*Only complete this section if your problem includes pain in your lower back or buttocks, otherwise please move on to the next section beyond this box.*

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

Indicate for each of the statements which number best describes your pain/complaint and how it has affected you **over the past few days**:

1) Over the past few days, on average, how would you rate your pain/complaint?

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

2) Over the past few days on average, how has your pain/complaint interfered with your daily activities (housework, washing, dressing, and sleeping)?

*no interference*        **0 1 2 3 4 5 6 7 8 9 10**                    *completely unable to carry on*

3) Over the past few days, on average, how has your pain/complaint interfered with your normal social routine including recreational, social and family activities?

*no interference*        **0 1 2 3 4 5 6 7 8 9 10**                    *completely unable to participate in any activity*

4) Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?

*not at all anxious*    **0 1 2 3 4 5 6 7 8 9 10**                    *extremely anxious*

5) Over the past few days, on average, how depressed (down-in-the-dumps, sad, low in spirits, pessimistic, lethargic) have you been feeling?

*not depressed*        **0 1 2 3 4 5 6 7 8 9 10**                    *extremely depressed*

6) Over the past few days, on average, how do you think your work (both inside the home and/or employed work) have affected your pain/complaint?

*make it no worse*    **0 1 2 3 4 5 6 7 8 9 10**                    *make it very much worse*

7) Over the past few days, on average, how have you been able to control (help/reduce) and cope with your pain/complaint on your own?

*I can control it completely*        **0 1 2 3 4 5 6 7 8 9 10**                    *I have no control whatsoever*