



New Client Case History

Please print clearly

First Name: _____

Last Name: _____

DOB: ____/____/____

Sex: _____

Email: _____

Contact Number: _____

Address: _____

Postcode: _____

Reason for this visit

Occupation: _____

What is the purpose of this visit?

Company: _____

Wellness Complaint Injury Other

Marital Status: _____

Emergency contact: _____

Next of Kin: _____

How were you referred to our office?

GP Details

GP Name: _____

GP Practice: _____

Contact no: _____

Address: _____

Other significant/previous health care provider

Name: _____

Practice: _____

Contact no: _____

Address: _____

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible care

Give a description of the problem you are experiencing presently _____

Is it getting worse? Yes No

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

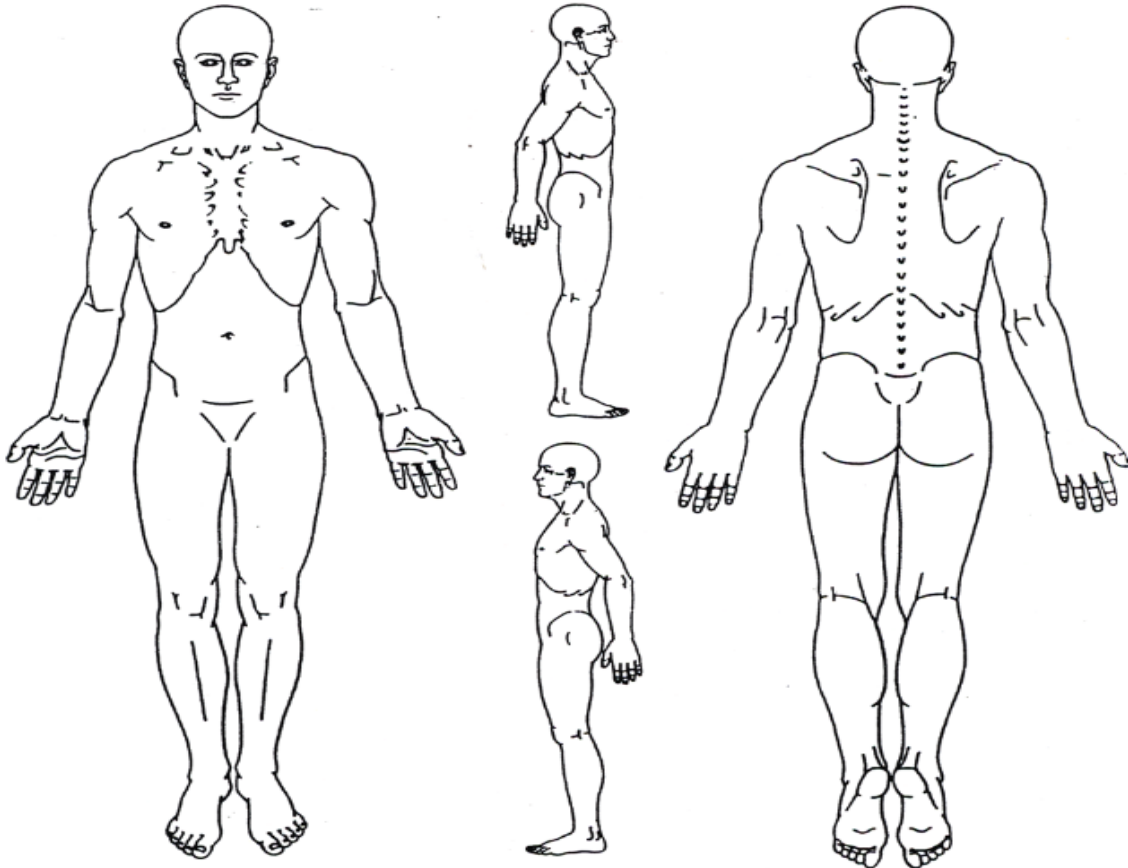
HOW LONG HAVE YOU HAD THIS PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? _____ YES _____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER



What is your main complaint?

Have you had any Diagnostic tests performed? (I.e. x-rays/MRI/CT scan/blood tests). What were the results?

What are your future Health Goals?

SF-36v2 Completed Yes No

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick one box.)

Excellent

Very Good

Good

Fair

Poor

2. Compared to one year ago, how would you rate your health in general now? (Please tick one box.)

Much better than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please circle one number on each line.)

	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) Lifting or carrying groceries	1	2	3
3(d) Climbing several flights of stairs	1	2	3
3(e) Climbing one flight of stairs	1	2	3
3(f) Bending, kneeling, or stooping	1	2	3
3(g) Waling more than a mile	1	2	3
3(h) Walking several blocks	1	2	3
3(i) Walking one block	1	2	3
3(j) Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Please circle one number on each line.)

	Yes	No
4(a) Cut down on the amount of time you spent on work or other activities	1	2
4(b) Accomplished less than you would like	1	2
4(c) Were limited in the kind of work or other activities	1	2
4(d) Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? (Please circle one number on each line.)

	Yes	No
5(a) Cut down on the amount of time you spent on work or other activities	1	2
5(b) Accomplished less than you would like	1	2
5(c) Didn't do work or other activities as carefully as usual	1	2

6.	During the <u>past 4 weeks</u> , to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick one box.)																																																																						
Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely <input type="checkbox"/>																																																																							
7.	How much <u>physical</u> pain have you had during the <u>past 4 weeks</u> ? (Please tick one box.)																																																																						
None <input type="checkbox"/> Very mild <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/>																																																																							
8.	During the <u>past 4 weeks</u> , how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)? (Please tick one box.)																																																																						
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9.	These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u> . Please give the one answer that is closest to the way you have been feeling for each item.																																																																						
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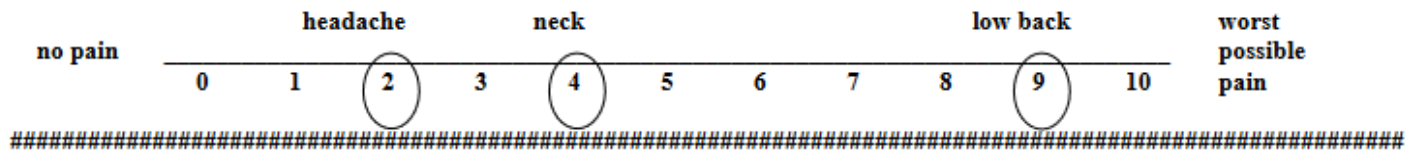
Thank You!

QUADRUPLE VISUAL ANALOGUE SCALE

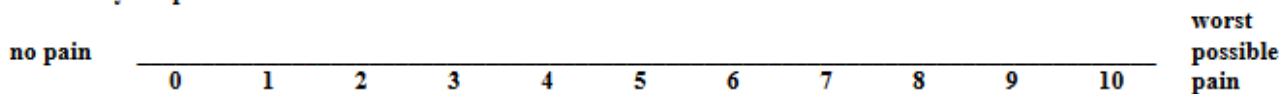
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

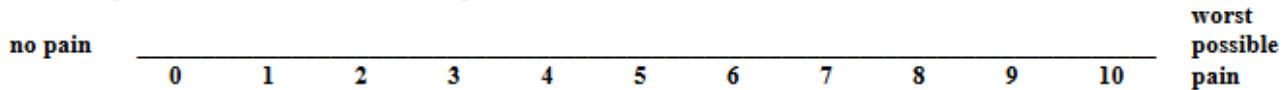
EXAMPLE:



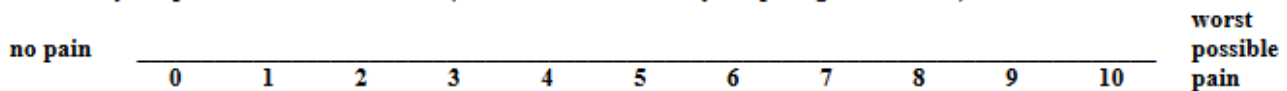
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

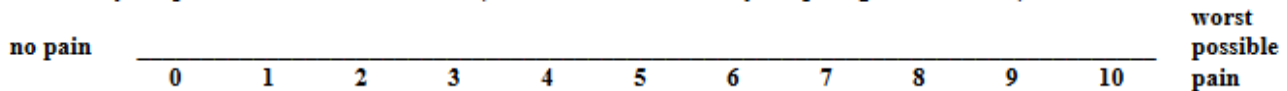


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____ %

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____ %

