To enable us to organise an appropriate appointment for you we ask that you complete the enclosed Patient Detail Questionnaire and return to our office as soon as possible. If not previously forwarded, please include the following:

- GP Referral
- X-Ray or Scan Reports (Films are not required at this point)

Please bring your films on the day of your appointment.

The above forms can be mailed, faxed or emailed to our office.

Current address: Dr John Albietz
QCOS Orthopaedic
Suite 14 Level 10
Evan Thomson Building
24 Chasely Street
Auchenflower Qld 4066

Fax: 07 3721 8666

Email: admin@qcos.net.au

The information received will be reviewed by Dr Albietz and we will contact you by mail within 7 working days with an appointment date and time.

Thank you for your understanding and co-operation. If you have any further questions please do not hesitate to contact our office on 07 3721 8600.

DATE: ____/____/ ____ **JA**

Title: Mrs Miss Ms Mr Mast Dr

Family Name: ______________________________ Given Name: ____

Address: ____

Date of Birth: ____/____/____ Occupation: ___________________________ Email: ___________________________

Ph: (h) __________________ (w) __________________ Mobile ____

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ Exp date: ___________________________________

Medicare Reference Number (Small Number in front of your name): ☐

Dept. Of Veteran Affairs No: _________________ Exp: _____/_____/_____ ☐Gold Card / ☐White Card

Health Care Card / Pension No: _________________________________ Exp: /______/________________________

Are you a member of a Private Health Fund: Yes / No

Health Fund: _________________________________ Membership No: _____________________________________

Level of Cover (Please tick): ☐ Full Private Hospital ☐ Extras Only

Have you served the twelve month waiting period Yes / No

ACCOUNT PAYMENT DETAILS

☐ Self

☐ Workcover Claim No: ____

Company/Employer ____

☐ Other Details: ____

REFERRAL DETAILS

Referring Doctor Name: ____

Address: ____

Usual GP ***(If different from referring doctor)*** ___________________________

Address: ____

NEXT OF KIN DETAILS

Next of Kin: ____________________________________ (Relationship) ___________________________________

Address: ____

Phone: ____________________________________

PATIENT CONSENT

I give permission for you to disclose to any doctor, health authority, allied health provider, rehabilitation provider, Workcover Insurer and its agents, or other insurer any information about my medical history relevant to my treatment.

Signature: ____________________________________ Date: ____

X-RAYS

The QCOS Orthopaedic does not store x-rays / scans for any period of time exceeding twelve months. It is essential that you keep the scans in your possession at all times.

I hereby understand that the QCOS Orthopaedic will destroy any x-rays or scans left in their possession after twelve months, without prior notice.

Signature: ____________________________________ Date: ____

Patient Health Questionnaire

Patient Name: ______________________________ DOB: ____________

Do you currently smoke? ☐ Yes ☐ No

Are you an ex smoker? ☐ Yes ☐ No

1. Do you have a history of:

		Please specify:
Deep Vein Thrombosis (DVT)	☐ Yes ☐ No	
Pulmonary Embolism (PE)	☐ Yes ☐ No	
Blood Clotting Disorders	☐ Yes ☐ No	
Do you have a family history of DVT or PE	☐ Yes ☐ No	
Arthritis (Osteo, Rheumatoid, Gout etc)	☐ Yes ☐ No	

2. Please list any current or previous medical problems.

1.
2.
3.
4.

3. Have you had any previous operations? ☐Yes ☐ No

Operation	When (Year)	Doctor
1.		
2.		
3.		
4.		

4. Are you taking any of the following medications?
If yes, please discuss with your doctor

- Plavix, Clopidgrel, Wafarin, Aspirin, Cartia ☐Yes ☐ No
- Hormone Replacement ☐Yes ☐ No
- Oral Contraceptives ☐Yes ☐ No

5. Please list all other medications.

Medication: *eg Panadol*	Dose: *eg 1 gram*	Frequency: *eg* 4 per day	Route: *capsule*

6. Please list any allergies

Medication / Substance	Reaction

7. Have you had any other back/neck complaints:

1.______________________________

2.______________________________

Patient Name:____ DOB:_____________________

Do you have a current legal claim regarding this condition? ☐ Yes ☐ No

Are you seeing a Solicitor for this condition? ☐ Yes ☐ No

Will you need a legal report? ☐ Yes ☐ No

<u>**Please indicate on this diagram where your pain is located.**</u>

Mark areas of pain using shading.

Mark areas of tingling or pins and needles with crosses.

Please mark your current level of neck pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.

|___|___|___|___|___|___|___|___|___|___|

0 1 2 3 4 5 6 7 8 9 10

Please mark your current level of arm pain on the scale below.

0 is no pain and 10 is the worst pain imaginable.

|___|___|___|___|___|___|___|___|___|___|

0 1 2 3 4 5 6 7 8 9 10

Patient Name: ____ _____________DOB: _________________

This questionnaire has been designed to give the doctor information about how your back pain has affected your ability to manage in everyday life. Please answer each section and mark only one box per section that applies best to you. We realise that you may consider that two of the statements may apply to you, but please **only mark the box** that best describes your problem.

Neck Pain Questionnaire

Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is worst imaginable at the moment

Concentration

- ☐ I can concentrate fully with no difficulty
- ☐ I can concentrate fully but with slight difficulty
- ☐ I have a mild degree of difficulty in concentrating
- ☐ I have a moderate degree of difficulty in concentrating
- ☐ I have severe difficulty in concentrating
- ☐ I cannot concentrate at all

Personal Care

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of personal care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

Lifting

- ☐ I can lift heavy objects without extra pain
- ☐ I can lift heavy objects but it gives extra pain
- ☐ I can only lift heavy objects if they are conveniently positioned
- ☐ I can only lift light/medium objects if they are conveniently positioned
- ☐ I can only lift very light objects
- ☐ I cannot lift or carry anything at all

Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I can't drive my car as long as I want because of moderate pain
- ☐ I can hardly drive at all because of severe neck pain
- ☐ I can't drive my car at all

Reading

- ☐ I can read as long as I wish without pain
- ☐ I can read as long as I wish but it causes slight neck pain
- ☐ I can read as long as I wish but it causes moderate neck pain
- ☐ I can't read as long as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all

Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ My sleep is completely disturbed (5-7 hours sleepless)

Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which occur infrequently
- ☐ I have moderate headaches which occur infrequently
- ☐ I have moderate headaches which occur frequently
- ☐ I have severe headaches which occur frequently
- ☐ I have headaches almost all the time

Recreation

- ☐ I can do all my recreation activities with no neck pain
- ☐ I can do all my recreation activities with some neck pain
- ☐ Pain mildly restricts my usual recreation activities
- ☐ Pain moderately restricts my usual recreation activities
- ☐ I can hardly do any recreation activities because of neck pain
- ☐ I can't do any recreation activities at all

Office Use Only

_______/_______

_________%

Patient Name: ______________________ DOB: ______________

Height: (cm) ______________

Weight (kg) ______________

What date did the injury occur? ______________________

How did the injury occur? ______________________

____

Have you had any previous treatment with regards to this injury? Eg: Physiotherapy, Chiropractic, Occupational Therapy, Psychology, Injections, Pain Medication, Acupuncture etc.

____

____

If you have had any of the above treatment, when did it commence and how often have you been having treatment?

____

____

Have you seen any other Specialists with regards to this injury?

☐ Yes Name of Specialist/Specialists ______________________

☐ No

Have you had any x-rays, CT scans or MRI's taken with regards to this injury?

☐ Yes

Please list the tests that you have had: ______________________

☐ No

Are you currently working?

☐ Yes

☐ No How long have you been off work? ______________________

Patient Name: ______________________________ DOB: ____________________

<u>WorkCover Patients Only</u>

WorkCover Claim No: ____________________

WorkCover Claim Manager: ____________________ **Ph:** ____________________

Employer Name: ____________________

Employer Phone No: ____________________

Before this accident, did you have any condition or injury that affected this part of your body?

____

____

Have you had any other previous WorkCover claims?

____

____

<u>WorkCover Patients Only</u>

Important Information

It is very important that your WorkCover Medical Certificates are kept up to date at all times. Please request a new certificate from your doctor at each appointment, if required.

Your consultations will only be paid by WorkCover if they hold a current Medical Certificate.

It is the patient's responsibility to give a copy of the Medical Certificate to WorkCover and the Employer. This certificate is also to be given to anyone that is providing treatment eg: Physiotherapist, Chiropractic, Occupational Therapist, Hand Therapist etc

A current referral must be held by our office at all times.

Medical Certificates will not be issued over the phone.

Signature: ______________________________ **Date:** ______________________________