OccPhyz CONSULTING

Pre-Examination Questionnaire

4 pages to complete

PLEASE COMPLETE THIS FORM & EMAIL TO INFO@OCCPHYZ.COM.AU 5 DAYS BEFORE YOUR APPOINTMENT

Today's Date:	**Location of Consultation**:

PATIENT INFORMATION

Title:	First:	Middle:	Surname:

Dependent Children:	Marital Status:	DOB:	Age:	Sex:

Address:

Home Phone:	Mobile:	Work:

Email Address:	Country of Birth:

Medicare No:	Ref:	Exp Date:	Are you Aboriginal/Torres Strait Islander? ☐ Yes ☐ No

Veteran's Affairs No:	Dominant Hand:	**WEIGHT:** KG **HEIGHT:** CM	**BMI:**

IDENTIFICATION

Your Photo ID must be presented on the day of appointment or our doctor cannot assess you. Your photo ID must be current and in the name of your booking.

We do not accept Bank cards, Medicare card, or other ID without photo.

Name changes: You must have evidence on the day, such as certificate of marriage or official government letter of name change, if booking is past name.

Photo ID: Driver's License / Passport / 18+ Card / Other: Card/ License Number: Expiry Date:

MEDICATIONS

MEDICATIONS (include all medications including over the counter)	**Dosage**	**Frequency**	**Reason for taking**

CURRENT MEDICAL INFORMATION

Current GP / Clinic:	**Allergies:**

Pregnant: If Yes: weeks	**Alcohol** - Quantity: Choose an item. Frequency: Choose an item.	**Tobacco**: ☐ Never ☐ Ex-smoker ☐ Yes: per day

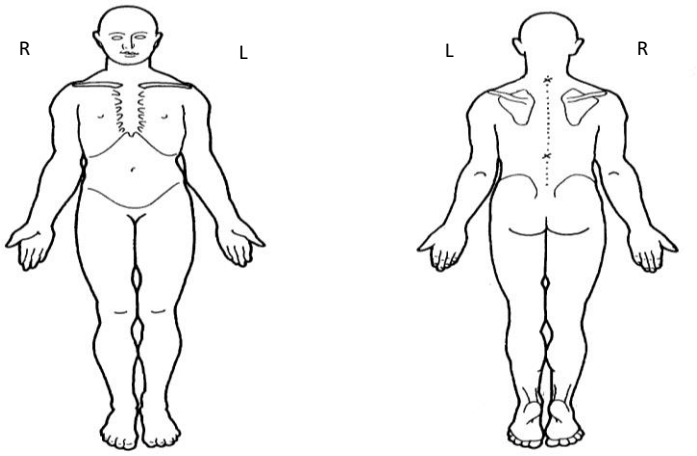
PAST MEDICAL HISTORY

Condition:	**No**	**Yes**	**If Yes – Please provide further information**	**Date**
Asthma and/or Lung Disease/ Illness	☐	☐		
Diabetes	☐	☐		
Epilepsy	☐	☐		
High Blood Pressure / Heart Disease	☐	☐		
Blood Disorders	☐	☐		
Cancer	☐	☐		
Kidney Disorders	☐	☐		
Stomach or Bowel Disease / Illness	☐	☐		
Back Pain / Neck pain	☐	☐		
Limb Joint pain or conditions	☐	☐		
Psychiatric Disorders e.g. Depression / Anxiety / Bipolar	☐	☐		
Skin rash or condition	☐	☐		
Other:	☐	☐		

Please list your past operations or surgery:	Please provide further information	Date

PAIN ASSESSMENT

1. Location of Pain – Please mark the following images where pain is felt



2. Rate your pain as it is NOW / TODAY:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8☐ 9 ☐ 10☐

Low Moderate High

3. On an average day; rate your pain from least severe to most painful (circle 2 numbers)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Low Moderate High

4. Words to describe your pain:

☐ Aching	☐ Nagging	☐ Exhausting	☐ Sharp
☐ Shooting	☐ Miserable	☐ Penetrating	☐ Numb
☐ Burning	☐ Stabbing	☐ Throbbing	☐ Tender
☐ Unbearable	☐ Tiring	☐ Gnawing	☐ Stinging

5. Is your pain: ☐ Intermittent ☐ Constant

6. Does the pain radiate? ☐ No ☐ Yes:

7. What time of day is your pain the worst or most noticeable?

8. What makes the pain <u>better</u>?

•

9. What makes the pain <u>worse</u>?

•

10. Please indicate how the injury/illness affects your activities of daily living? ☐ **No** ☐ **Yes - If yes, please detail how.**

☐ Self-Toileting	_____	☐ Work	_____
☐ Self-Dressing	_____	☐ Housework	_____
☐ Bathing	_____	☐ Driving	_____
☐ Meal Preparation and Cooking	_____	☐ Sleep	_____
☐ Gardening and Mowing	_____	☐ Relationships	_____
☐ Caring for family/pets	_____	☐ Sports/Hobbies	_____
☐ Concentration/Memory		☐ Socialising	

11. Are you experiencing any other symptoms? (Tick as many as relevant)

☐ Nausea/ Vomiting	☐ Sleepiness	☐ Weight Gain or Loss	☐ Mental health issues	☐ Headaches
☐ Bladder or Bowel Issues	☐ Shortness of Breath	☐ Dizziness	☐ Difficulty Concentrating	☐ Skin issues

12. With respect your emotions, how have you been feeling in the past <u>four weeks</u> (last month)? Please tick the relevant box below.

In the past <u>4 weeks</u>:	None of the time	A little of the time	Some of the time	Most of the time	ALL of the time
1. About how often did you feel tired for no good reason?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. About how often did you feel nervous?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. About how often did you feel so nervous that nothing could calm you down?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. About how often did you feel hopeless?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. About how often did you feel restless or fidgety?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. About how often did you feel so restless you could not sit still?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. About how often did you feel depressed?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. About how often did you feel that everything is an effort?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. About how often did you feel so sad that nothing could cheer you up?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10. About how often did you feel worthless?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

EDUCATION HISTORY

Completed School level: ☐ Year 10 ☐ Year 12 ☐ Other

Tertiary or Trade Qualifications: (Please list)	Year Completed:
☐	☐
☐	☐
☐	☐
☐	☐

EMPLOYMENT (LIST ALL JOBS)

Occupation:	Employer:	Part Time /Full Time / Casual / Other	Date Commenced / Ceased employment

Reason for extended periods out of workforce: (family commitments, injury/illness, unable to find work etc.) Please describe:

Have you served or currently serving in the **Australian Defence Force** or any other Military organisation? ☐ No ☐ Yes:

If Yes, please provide details:

SUPPORT PERSON / CHAPERONE

Do you have a Support Person with you today attending your consultation? ☐ No ☐ Yes If yes, what is their name:

We are able to offer a Chaperone support for your examination. Would you like our staff member to be present for your examination only?

☐ No ☐ Yes - Name of Chaperone:

FINANCIAL RESPONSIBILITY

Are you financially responsible for today's consultation? ☐ No ☐ Yes

If No, who is paying for consultation/report today? ☐ WorkCover ☐ Solicitor ☐ Insurer ☐ Employer ☐ DVA

DECLARATION

I_____, state the above personal information was ☐ completed by me; and is true and correct to the best of my knowledge.

Signed: _____ Date:

If this document was completed with the assistance of another person, please complete these details below:

Name of person completing this document: _____

Relationship to patient/client: ☐ Partner ☐ Guardian ☐ Friend/Colleague ☐ Interpreter ☐ Solicitor ☐ Other:

Your Contact details: _____

Now continue over to sign your Consent Form for your assessment

Your Name: _____
(enter full name)

Please tick ☒ all boxes to acknowledge you have read and agree to consent below.

☐ I consent to undergo a medical examination with Specialist Occupational Physician.

☐ I understand that my assessment will involve a detailed medical, occupational and social history and a relevant physical examination.

☐ I understand that my medical letter/report will be sent directly to the referrer.

☐ I give permission for my medical information, medical report/s and clinical notes be supplied to my Specialist if requested, in order for him/her to assess my health for the purposes of:

_____
(Reason for appointment today)

☐ I confirm that I have read the above consent to my satisfaction.

Examinee/Patient Signature: _____

Witness Name: _____

Witness Signature: _____ Date:

Witness must be over 18 years of age, known to the patient who witnesses you signing your consent form.

Please return this form to info@occphyz.com.au at least 5 days before your appointment.