

*Welcome to Next Generation Occupational Medicine.*

*Please complete this form upon arrival and return to reception.*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin & Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many hours work per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor & Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you been employed? \_\_\_\_\_\_\_\_\_\_\_\_

Insurance Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating doctor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic name/address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I CONSENT TO THE BELOVE:**

* **Work Cover and Motor Vehicle Accident Claimants: I acknowledge that I am responsible for payment of all accounts associated with treatment of my injury if my insurer or employer suspends or discontinues payments.**
* **Next Generation Occupational Medicine recording and sharing information obtained from me. I understand that this may be shared with laboratories, radiological facilities, other health service providers, rehabilitation consultants, insurers, medical defence organisations, lawyers or my employer for the purpose of investigation, treatment and rehabilitation of my injury or illness, *unless otherwise specified*. I understand that I may revoke this consent at any time in writing.**
* **I understand that all appointments need to be attended. If the practice is not notified of a cancellation on 3 occasions, I understand that I will be dismissed from the doctors’ care.**
* **I authorise and consent for Next Generation Occupational Medicine to obtain copies of all imaging results, other results, and reports conducted in relation to the concerned injury.**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**



**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

***Please skip this page if you are not experiencing any pain.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **How long have you had your current pain problem? Circle one.** | | | | | | | | | | | | | | | |
| 0-1 weeks (1) | | | 1-2 weeks (2) | | | 3-4 weeks (3) | | | 4-5 weeks (4) | | | 6-8 weeks (5) | | | [ ] |
| 9-11 weeks (6) | | | 3-6 months (7) | | | 6-9 months (8) | | | 9-12 months (9) | | | Over 1 year (10) | | |  |
| 1. **How would you rate the pain that you have had during the past week? Circle one** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| No Pain |  |  | |  |  | |  |  | |  | Pain as bad as it could be | | | | |
| 1. **I can do light work (or home duties) for an hour. Circle one.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10- | [ ] **10-** |
| Not at all | |  | |  |  | |  |  | |  | Without any difficulty | | | | |
| 1. **I can sleep at night. Circle one.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10- | [ ] **10-** |
| Not at all | |  | |  |  | |  |  | |  | Without any difficulty | | | | |
| 1. **How tense or anxious have you felt in the past week? Circle one.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| Absolutely calm & relaxed | | | |  |  | |  |  | | As tense & anxious as I have ever felt | | | | | |
| 1. **How much have you been bothered by feeling depressed in the past week? Circle one.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| Not at All |  |  | |  |  | |  |  | |  |  | | Extremely | | |
| 1. **In your view, how large is the risk that your current pain may become persistent? Circle one.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| No Risk |  |  | |  |  | |  |  | |  |  | | Very Large Risk | | |
| 1. **What do you estimate are the chances you will be working your normal duties (home or work) in 3 months?** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10- | [ ] **10-** |
| No Chance |  |  | |  |  | |  |  | |  |  | | Very Large Chance | | |
| 1. **An increase in pain is an indication that I should stop what I’m doing until the pain decreases.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| Completely Disagree | | | |  |  | |  |  | |  |  | | Completely Agree | | |
| 1. **I should not do my normal work (at work or home duties) with my present pain.** | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | | 3 | 4 | | 5 | 6 | | 7 | 8 | | 9 | 10 | [ ] |
| Completely Disagree | | | |  |  | |  |  | |  |  | | Completely Agree | | |

SUM:



**Medical History**

**Are you right or left-handed?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please describe to the best of your ability, the injury or medical condition(s) that is currently affecting you:*

**Date and location of injury / illness**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief description of the event** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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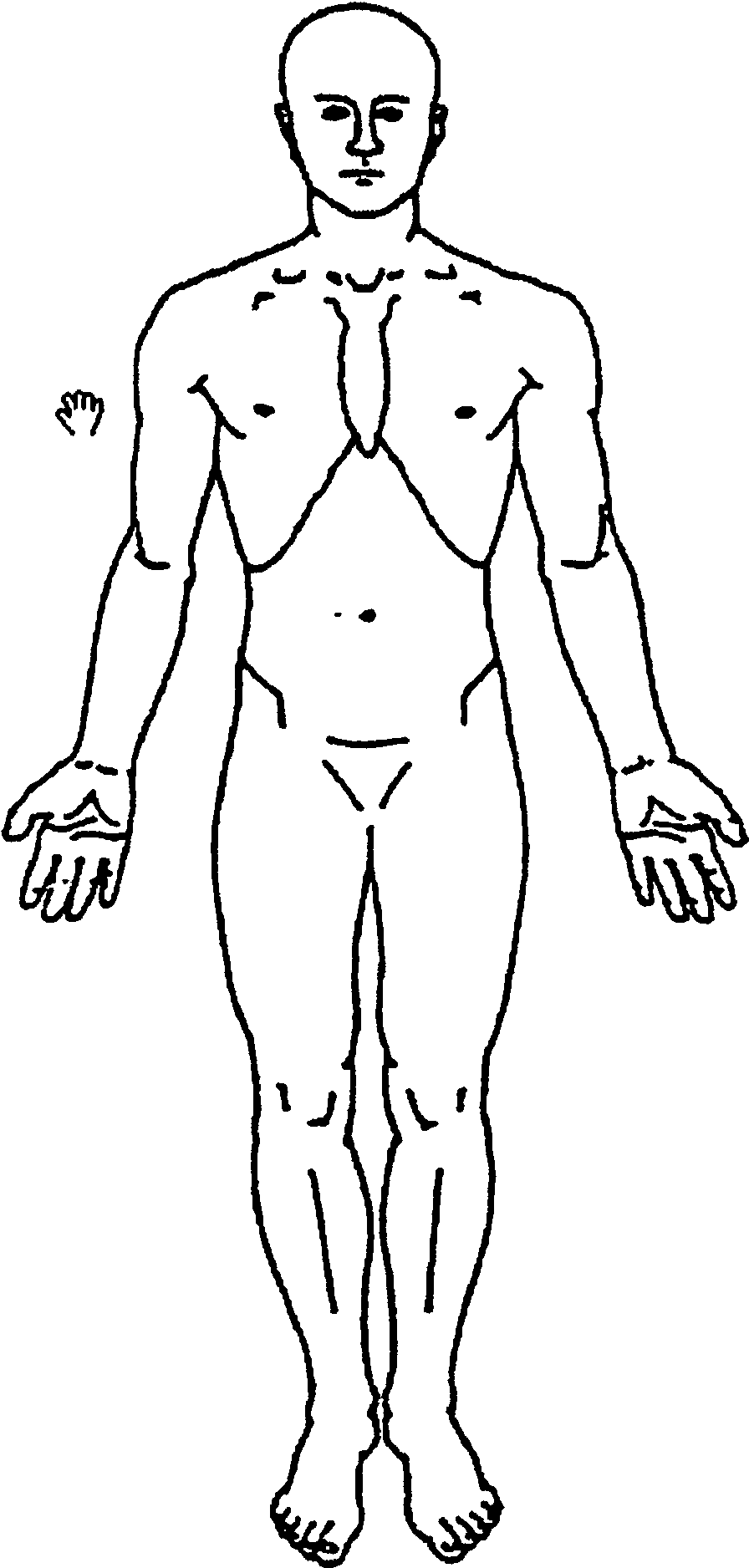
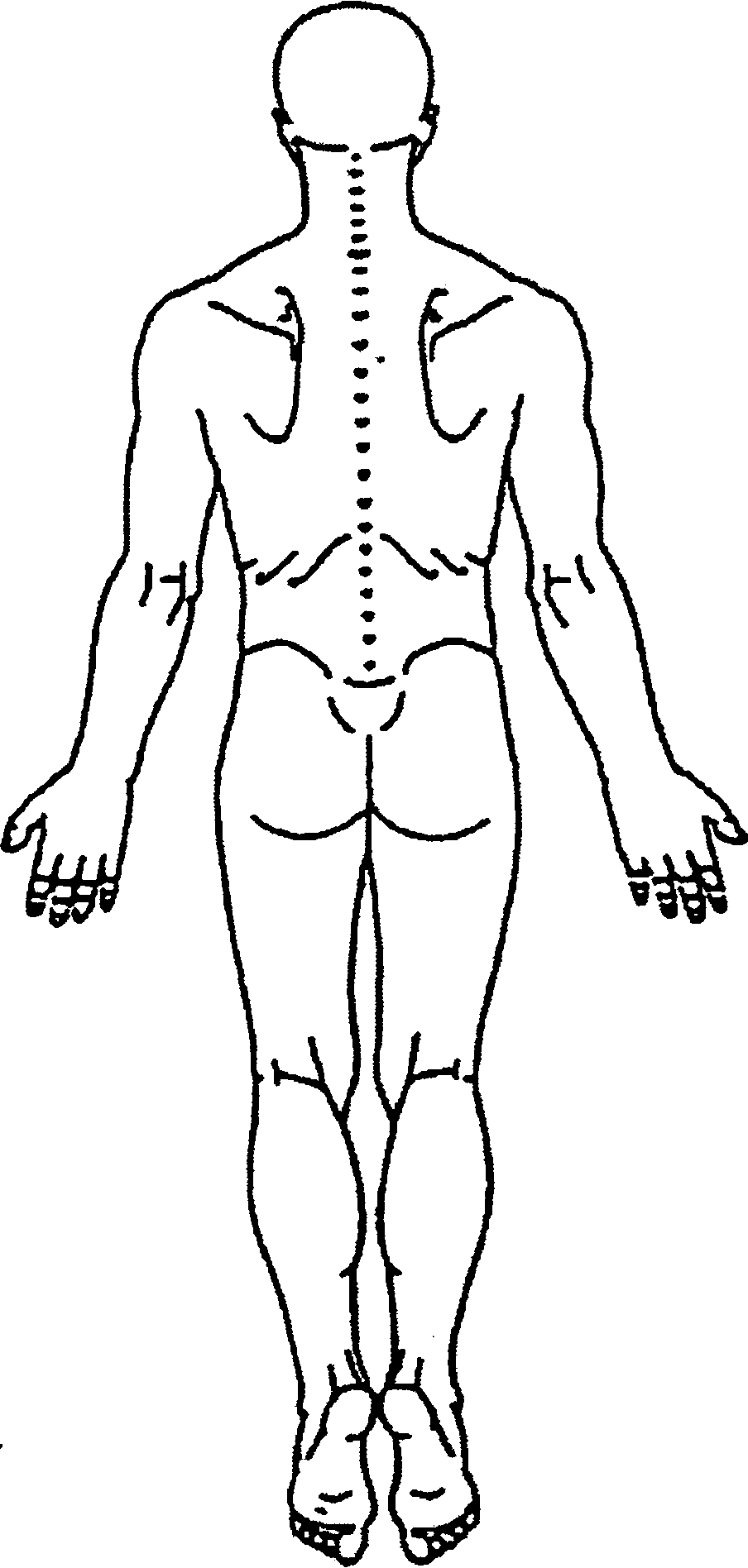
**What problems and symptoms are you currently having?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Description of injury or injuries (please use diagram to indicate where you feel pain – please include ALL affected areas)** *Please mark on the diagram the site of pain. Also mark your worst pain with an ‘x’ and mark any numbness with an ‘o’*

**Investigations**

Please tick (✓) if you have had the following investigations for current injury and list approximate dates

□ X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CT Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Ultrasound \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Nerve Studies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Blood Tests \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current treatment for injury** (please tick ✓)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Treatment type** | |  | **Number of sessions** | | | |  | **Helpfulness** | | |
| Physiotherapy | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Chiropractic | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Hydrotherapy | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Gym | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Psychology | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Acupuncture | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| TENS | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Massage | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |
| Other | Yes □ No □ |  | 1-5 □ | 6-10 □ | 11-20 □ | >20 □ |  | nil □ | some □ | very □ |

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication**

Please list **ALL** medication you are **currently** taking(including those for pain) and indicate (tick box) whether or not they are helpful.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Benefit** (tick box) | | | |
| **Medication** | **Dose** | **Side effect** | **none** | **mild** | **moderate** | **marked** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |

**Past Medical History**

|  |  |  |
| --- | --- | --- |
| **Condition** | **Treatment** | **Status** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Pre-injury Job and Duties**

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your pre-injury job duties and how do you do it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently off work? \_\_\_\_\_\_\_\_ Are you currently on work restrictions? \_\_\_\_\_\_\_\_ Reduced hours? \_\_\_\_\_\_\_\_\_\_\_\_\_

If so, please explain below (include hours, work restrictions specified by doctor and description of duties):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Education and Personal History**

Were you born overseas; if yes where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What level of school did you complete? \_\_\_\_\_\_\_\_\_\_\_\_

Have you obtained further qualifications; if so, please list them below? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Last 5 job positions**

Where and when did you work in your last 5 years? Please include periods of unemployment or study:

|  |  |  |  |
| --- | --- | --- | --- |
| **Period/Year** | **Job Title** | **Employer** | **Reason for Leaving** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Psychosocial History**

Who else lives with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any dependents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hobbies/interests do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had to change or give up any hobbies/ interests as a result of your injury(s)? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you a smoker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if so, please indicate how much): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if so, please indicate how much): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**