

Patient Initial Assessment

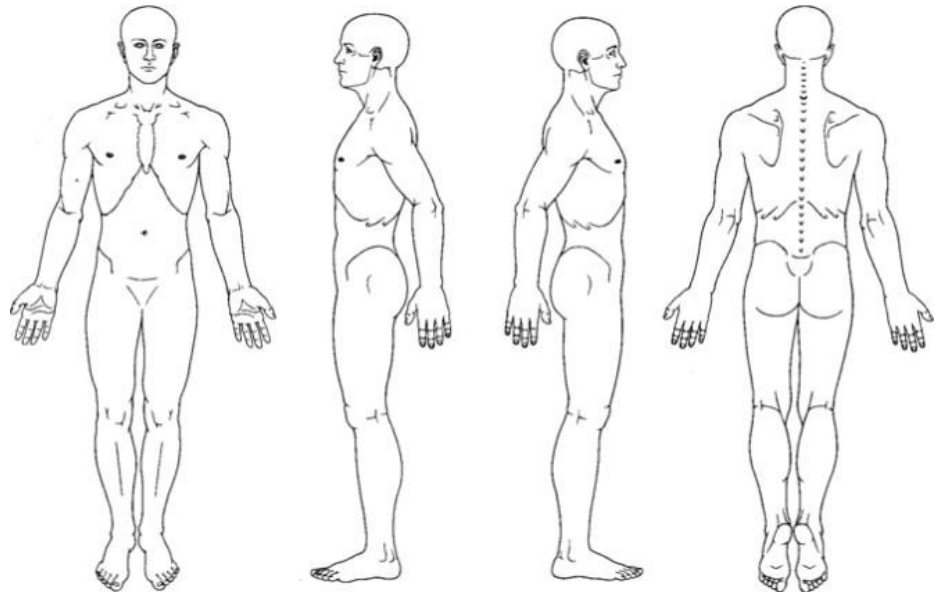
Thank you for taking a few minutes to complete the following information about your personal health. This information is important for us to be able to carry out your treatment effectively. By completing this assessment form you are consenting to this information being shared with the clinical staff caring for you. Some of it may also be used for clinical audit or administrative purposes and personal information will be anonymised wherever possible. All information will be kept confidential in line with our Data Protection Policy.

Name:		Date:
Date of Birth:	Intern:	File Number:

Please select your area(s) of pain by drawing circles on these images

Office Use Only

- Cervical
- Thoracic
- Lumbar
- Headache
- Shoulder
- Hip
- Upper Limb
- Lower Limb
- Wellness



Information about your condition

How long has THIS PRESENT episode of your complaint lasted?

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> More than 10 years | <input type="checkbox"/> 6-10 years |
| <input type="checkbox"/> 3-5 years | <input type="checkbox"/> 1-2 years |
| <input type="checkbox"/> 7-12 months | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> Less than 3 months – if so, how many days has THIS PRESENT episode lasted?..... | |

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, please answer the background medical questions below. Do you have or have you ever had treatment for:

Problems with circulation, blood pressure or heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis or orthopaedic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung or breathing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestive problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney or bladder problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or neurological problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety, depression, stress or psychological problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer or tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Initials:

Intern Initial

Supervisor Initial

Pre-examination medical history information (continued)

Are you currently taking any medication including contraception?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any operations to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you suffered any significant injury as a result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Back Condition Information (for back pain only)

If you have been suffering from **back pain** specifically please answer the questions below. If not, please go straight to the next section.

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 **spread down my leg(s)** at some time in the last 2 weeks

Disagree Agree

I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks

Disagree Agree

I have only **walked short distances** because of my back pain

Disagree Agree

In the last 2 weeks, I have **dressed more slowly** because of my back pain

Disagree Agree

It's really not safe for a person with a condition like mine to be physically active

Disagree Agree

Worrying thoughts have been going through my mind a lot of the time

Disagree Agree

I feel that **my back pain is terrible** and **it's never going to get any better**

Disagree Agree

In general I have **not enjoyed** all the things I used to enjoy

Disagree Agree

Additional Information

Please use this space to provide more information about your answers or anything you feel may be helpful for us to know:

Patient Initials: