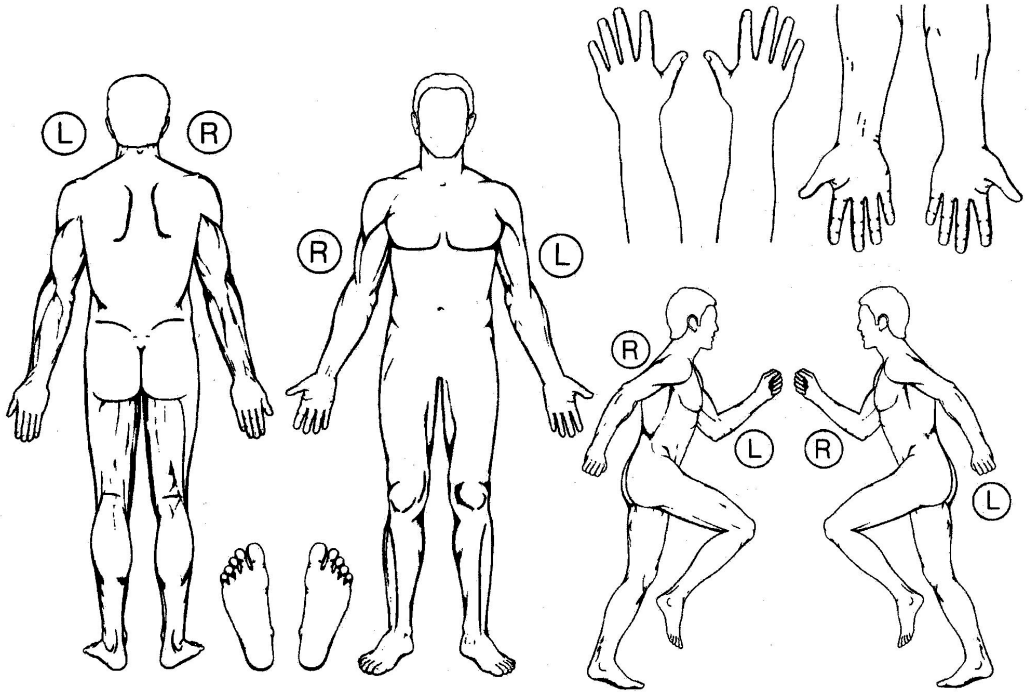
Pain and Medical Questionnaire

Name: _____ Date: ____/____/____ Age _____

We need to know about your medical history to ensure that we assess and treat your pain appropriately.

On the diagram below, shade in the areas where you feel pain. Place an 'X' at the worst pain.



In the past week, what number from 0 (no pain) to 10 (worst possible pain) represents your:

Highest pain Level _____ Lowest pain Level _____ Average Pain Level _____

What words would you use to describe what your pain feels like? (Circle/write any words below that apply)

Aching, Burning, Shooting, Electric shocks, Tingling, Pins and Needles, Numbness, Pricking. _____

What activities aggravate your pain? _____

What can you do to reduce your pain? _____

Do you experience any weakness, numbness or change in bladder control with your pain?

When did your pain start? _____

What do you understand your pain is due to? _____

In the past week, to what extent from 0 (no interference) to 10 (complete interference) does the pain affect your:

Relationships	_____	Mobility	_____
Sleep	_____	Ability to look after yourself	_____
Employment/Ability to Work	_____	Mood	_____
Leisure activities	_____	Sexual activity	_____

Circle any of the following pain treatments you have tried?

Paracetamol	Cymbalta or Duloxetine	Cortisone Injections
Anti-inflammatories	Physiotherapy	Facet Joint Injections
Opiates or Narcotics	TENS	Nerve Blocks
Lyrica or Gabapentin	Psychology	Radiofrequency Treatments
Endep or Allegron	Pain Management Program	Spinal Cord Stimulators
Tramadol or Palexia		Pain Pumps

Do you have, or have you had, any of the following (please tick):

High blood pressure		Diabetes		Irritable bowel syndrome	
Heart attack or angina		HIV / AIDS		Fibromyalgia	
Blood Thinning Treatment		Stroke or TIAs		Painful menstrual periods	
Abnormal heart rhythm		Epilepsy		Drug or Alcohol Abuse	
Heart failure		Multiple sclerosis		Depression	
Asthma/bronchitis		Migraine		Anxiety	
Sleep apnoea		Liver disease		PTSD	
Bleeding disorders		Kidney disease		Other mental health	
Cancer		Recent weight loss		Other (explain)	

If you answered yes to any of the above, or if you have had any condition not listed above, please provide more information if you think we need to understand more

Condition	Details

Have you had any operations?

Operation	When?	Where?

Have you ever been hospitalized for a mental health condition? _____

Do you have suicidal thoughts? _____ Do you feel safe today? _____

Do you smoke? Non-smoker □ Ex-smoker □ Current smoker □ _____ per day

Do you drink alcohol? yes/no How many standard drinks do you have in a week? _____

Do you have a personal or family history of alcohol or drug misuse? _____

Please list your current medications (or provide a separate list of medications):

Medication name	Medication strength	Number taken & when taken

Do you have any allergies? Yes / No

If yes, what are you allergic to, and what happens? _____

What is/was your occupation? _____

Do you currently work Full-time □ Part-Time □ Not at all □

Who do you share your home with? eg spouse children house-mate etc

What would you like to achieve or discuss today?

Health Information Privacy Policy

Medical records containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information.

I acknowledge that:

☑ information about my health will be recorded by QPain Pty Ltd employees and contractors in a confidential file which may be scanned or paper based;

☑ my consent will apply to this and subsequent consultations, until withdrawn by me in writing.

I consent to allowing QPain Pty Ltd to:

☑ take a medical history and to collect personal information about me in order to attend to my health needs and for associated administrative purposes;

☑ pass on/discuss relevant medical information about me to my referring doctor and any health care provider to whom I am referred my consulting doctor;

☑ pass on/discuss relevant medical information about me to insurance or legal representatives (for example insurer, employer, solicitor) in the case of Third Party* or Workers' Compensation* matters. (*Delete whichever is not applicable);

☑ include information about my treatment on my printed receipt to enable me to claim my medical rebate entitlement;

☑ request relevant medical information regarding my medical history from other doctors or health care professionals involved in my care;

☑ recall me for follow up of medical problems as deemed necessary;

☑ disclose relevant de-identified medical information for research and quality assurance activities to improve individual and community health care and practice management;

☑ I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want;

☑ **Note:** If you are a guardian this policy is to be read as from the perspective of the patient for whom you are a guardian.

Signed _____ Name _____ Date _____