



name	
date of birth	
address	
date of accident	
time of accident	
height (cm)	
weight (kg)	
right or left handed	

Where did the Accident Occur?

Description of the Accident & Your Injuries

Please include the specific mechanism of the injury i.e. how did your injury occur?

For example:

- I tripped on the food material lying on the floor OR
- My foot slipped out from underneath me OR
- As I fell I landed heavily on my right side, injuring my right elbow.

Please list approximate dates for when the injuries occurred:



What Was The Nature Of Your Injuries Immediately Following The Accident?

For example: I suffered

1. A fracture of my right elbow.
2. Bruising of my right buttock.
3. An abrasion on my right knee.

Relevant Medical History

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

Time Off Work

Did you have time off work following the injury? If so, please give reasons why and the approximate dates and/or length of time off:

Are You Currently Working? Yes No Full Time Part Time

Are Your Duties The Same Or Reduced After The Incident?

Previous Legal Claims

Have you had any previous legal claims for other injuries or conditions? If so please give details:

Treatment

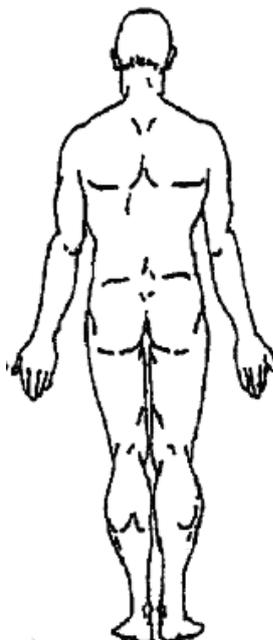
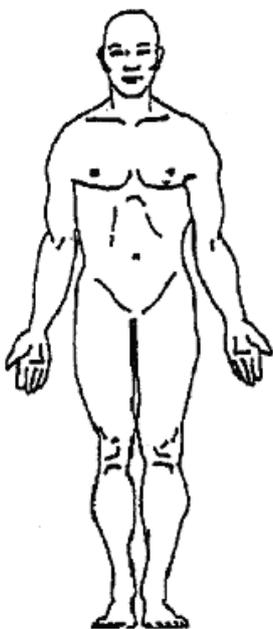
What treatment have you had to date?

Please include: surgery, injections, physiotherapy, splints, pain medications, weight loss or exercise programmes, acupuncture or chiropractic work.

Please also include approximate dates for each treatment. (eg "March 2004" or "early 2004")

Current Symptoms

Please indicate on this diagram where your pain is located



Please indicate on the graph your current pain level

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



Other Specialists

Which specialists have you seen for treatment for this condition?

Which specialists have you seen for a report or assessment of your condition?

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.

Back Pain Questionnaire

Pain Intensity

- I can tolerate the pain without having to use pain killers
- The pain is bad but I manage without taking pain killers
- Pain killers give complete relief of pain
- Pain killers give partial relief of pain
- Pain killers give very little relief of pain
- Pain killers have no effect on pain and I do not use them

Personal Care

- I can look after myself normally without 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

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 on a table
- I can only lift light / medium objects if they are on a table
- I can only lift very light objects
- I cannot lift anything, due to pain

Walking

- I can run or walk without pain
- I can walk comfortably but running is painful
- Pain prevents me from walking more than one hour
- Pain prevents me from walking more than 30 minutes
- Pain prevents me from walking more than 10 minutes
- I cannot walk more than a few steps at a time

Standing

- I can stand as long as I want
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 30 minutes
- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Sleeping

- I sleep well
- Pain occasionally interrupts my sleep
- Pain interrupts my sleep half of the time
- Pain often interrupts my sleep
- Pain always interrupts my sleep
- I never sleep well

Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but gives me extra pain
- Pain restricts more energetic social activities
- Pain has restricted my social life and I go out less often
- Pain has restricted my social life to home
- I have no social life because of pain

Travelling

- I can travel anywhere without extra pain
- I can travel anywhere but it causes some pain
- Pain is bad but I manage to travel over two hours
- Pain restricts me to trips of less than one hour
- Pain restricts me to trips of less than 30 minutes
- Pain prevents me from travelling except to the doctor



Back Pain Questionnaire

Sitting

- I can sit in any chair as long as I want
I can only sit in a special chair as long as I want
Pain prevents me from sitting more than one hour
Pain prevents me from sitting more than 30 minutes
Pain prevents me from sitting more than 10 minutes
Pain prevents me from sitting at all

Employment / Housekeeping

- My normal homemaking/ job activities don't cause pain
I can perform all these activities but do experience pain
I can perform most activities but do experience pain
Pain prevents me from doing anything but light duties
Pain prevents me from doing even light duties
Pain prevents me performing any job/ activities at all

Office Use Only

_____ / _____ %

Previous Investigations

Please list the tests that you have had for this problem and approximate dates for each investigation
i.e. x-rays, CT scans, MRI, Ultrasound:

Three horizontal lines for listing previous investigations.

Education

What level of education have you achieved?

- Junior Certificate TAFE
Senior Certificate University

Social

Please outline your social history.

- 1. Are you married or in a de facto relationship?
Yes _____
No _____
2. Do you have children?
Yes _____
No _____
3. What are their ages?
4. Who do you currently live with? _____
5. Do you own your own home or are you renting? _____



Employment History

Please outline your work history from when you left school. If more space is required please use the back of this page.

Table with 3 columns: PERIOD OF WORK, COMPANY, OCCUPATION/MAIN DUTIES

Additional Information

1. Please give the name and address of your solicitor:

Three horizontal lines for text entry.

2. Do you have a WorkCover claim for this condition?

If so, please provide your claim number.

Yes - CLAIM No: _____

No

3. Do you have an insurance claim for this condition?

Yes CLAIM No: _____ Who is the insurer for the claim: _____

No

Patient Consent

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

Signature: _____ Date: _____