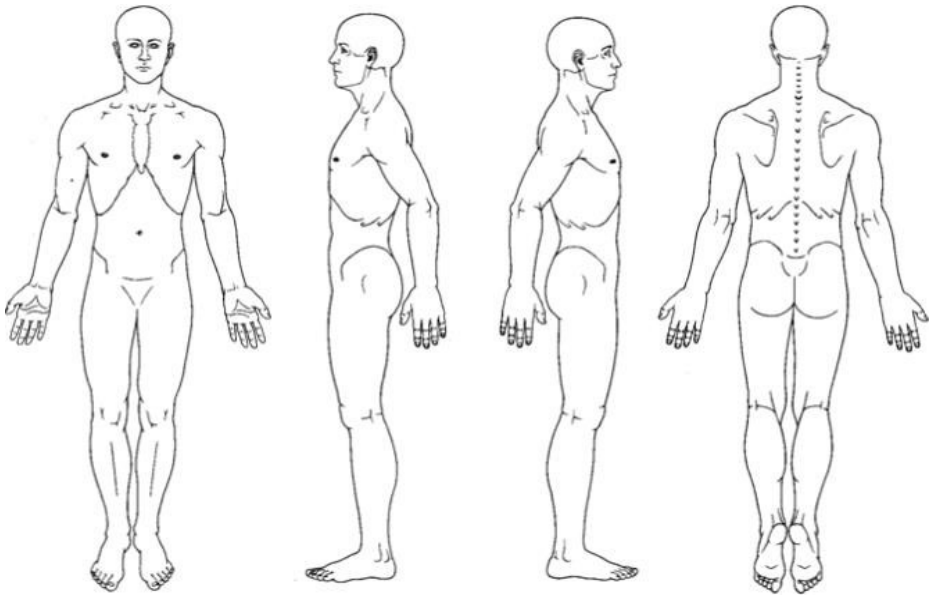
Patient Initial Assessment

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



Interns 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?

- ■ More than 10 years
- ❑ 6-10 years
- ❑ 3-5 years
- ❑ 1-2 years
- ❑ 7-12 months
- ❑ 3-6 months
- ❑ 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	■ Yes	❑ No
Arthritis or orthopaedic problems	❑ Yes	❑ No
Lung or breathing problems	❑ Yes	❑ No
Digestive problems	❑ Yes	❑ No
Kidney or bladder problems	❑ Yes	❑ No
Epilepsy or neurological problems	❑ Yes	❑ No
Anxiety, depression, stress or psychological problems	❑ Yes	❑ No
Allergies	❑ Yes	❑ No
Cancer or tumors	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No

Intern Initial _____ **Supervisor Initial**_____

Patient Initial Assessment (continued)

Pre-examination medical history information (continued)		
Are you currently taking any medication including contraception?	❑ Yes	❑ No
Have you ever had any operations to date?	❑ Yes	❑ No
Do you smoke?	❑ Yes	❑ No
Do you drink alcohol?	❑ Yes	❑ No
Have you suffered any significant injury as a result of an accident?	❑ Yes	❑ No
Are you currently pregnant?	❑ Yes	❑ 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:

Patients Signature: _____

Intern Initial_____ **Supervisor Initial**_____