South Coast Spine
TOTAL DISC REPLACEMENT

NEW PATIENT REGISTRATION FORM

Personal Information Please ensure you fill out where appropriate.			
Title: **Given names:**	**Last name:**		**D.O.B:**
Address:	**Suburb:**	**State:**	**Postcode:**
PO Box:	**Suburb:**	**State:**	**Postcode:**
Email:	**Home Phone: ( )**		
	Work Phone: ( )		
Mobile Number:	**SMS Notifications of appointment:** (please circle) **YES NO**		
Marital Status:	**Occupation:**		
Next of Kin: **Name:**	**Relationship:**	**Home phone: ( )**	
		Mobile Number:	
Department of Veterans Affairs: YES NO Please Circle: **Gold Card** **White Card** **DVA Number:**	**Medicare Number:** __ __ __ __ __ __ __ __ __ __ **Ref Number:** (next to name) **Exp:**		
Pension: YES NO Please Circle: **Aged** **Disability** **Health Care Card** **Pension Number:** **Exp:**	**Private Health Fund: YES NO** **Name of Fund:** **Level of Cover:** **Membership Number:**		
If your case is under the jurisdiction of WorkCover could you please provide us with your Medicare number, Health Fund and pension details.			

Referring Doctor Details: In order to see Dr Cleaver you will need a valid referral from a GP or Specialist.	
Referring Practitioner:	
Clinic:	
Address:	
Is your referring practitioner your regular GP? Please Circle: **YES** **NO**	
If NO, your regular GP:	
Clinic:	
Address:	

Work Cover, Motor Vehicle Accident and/or Insurance Companies: Please note that it is your responsibility to provide us with all of these details.		
Is your condition related to a current compensation claim or Work Cover Claim? Please Circle: **YES** **NO**		
Type of Claim:	**Employer:**	
Name of Work Cover/Insurer:	**Claim Number:**	
Case Manager:	**Address:**	**Direct Phone:** **Direct Fax:**
Lawyers:		
Do you have lawyers representing you on this claim: Please Circle: **YES** **NO**		
Name:		
Address:		**Tel:** **Fax:**

Your Information and Privacy Disclosure:

This practice, by necessity, collects personal and intimate details about its patients. Often patient's relatives and friends call to enquire about patient's wellbeing or to offer assistance in the patient's care. Please select the most appropriate box below:

☐ I **DO NOT** want any information about my being a patient in this practice communicated to any family members or friends. I want to be the **ONLY** person who communicates with the practice about my medical condition.

☐ I freely give my consent for this practice to communicate to family members and friends about the fact that I am patient of this practice and to discuss my health and personal information relating to my being a patient of this practice as the need arises.

This practice collects personal information about its patients. By filling out our forms containing your information you are giving your consent for this practice to collect and store information about you. We regard your information as confidential. As a patient of this practice you are entitled to know what information is used to communicate, as required, with other members of the practice and other practitioners involved in your care to diagnose and treat your condition, and to administratively make you a patient of this practice.

I, _____ consent to the use and disclosure of my personal information as outlined above.

Signed:_____ Date: _____/_____/_____

Parent/Guardian to sign if child is under 18 years.

Name:_____ Date:_____/_____/

Please answer the following questions:

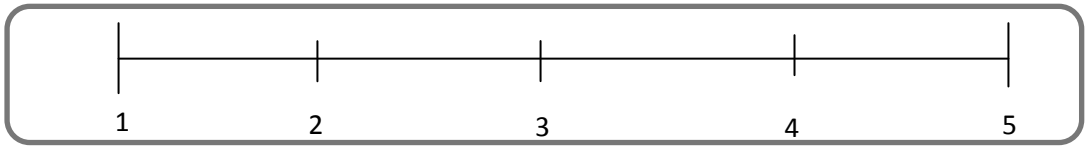
Please list any medications you are taking for your neck:

Please list what treatments you have for your neck and rate their success on a scale of 1 to 5:
(1 being no success, 3 being successful but short lived and 5 being very successful)

Please list your hobbies and interests:

Please list any hobbies/interests or sports that you would like to do but can't because of your neck:

On a scale of 1 to 5 how would you rate the physical demands of your occupation:
(1 being sedentary role only and 5 being heavy manual labour)



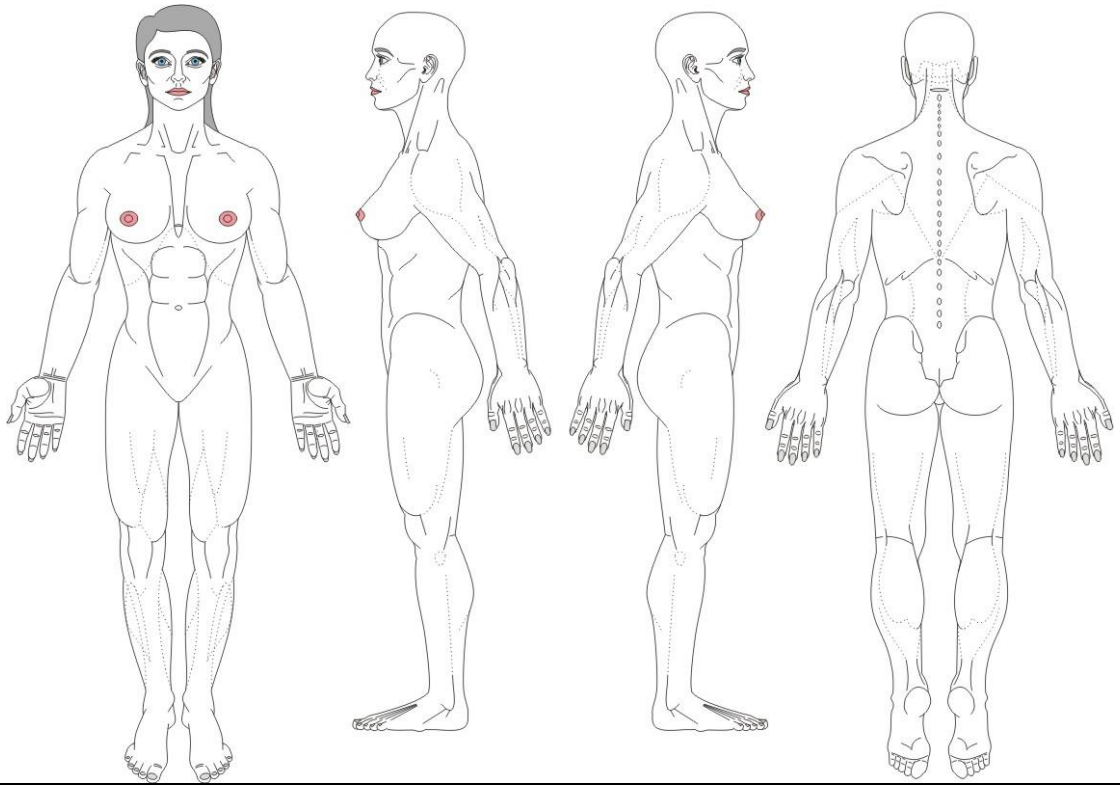
Do you have the capacity to perform light duties or a more sedentary role:

Name:_____ Date: ____/____/____

Your Pain Score – Female neck

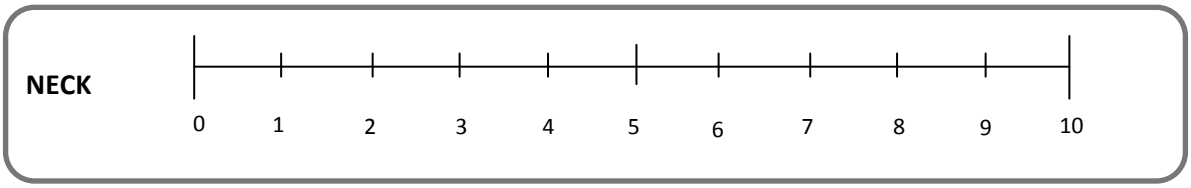
Please indicate on the schematic below the area where you feel pain:

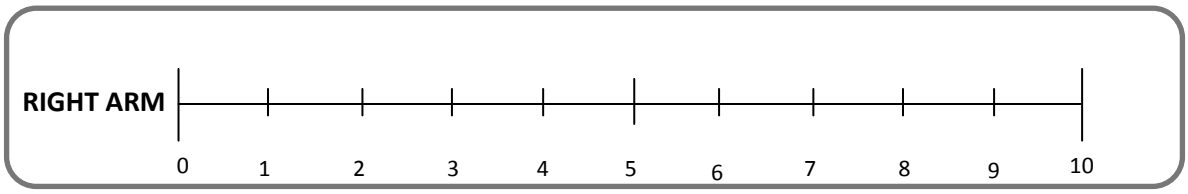
Either mark with a cross, colour or circle.



Please indicate by placing a cross on each line the intensity of your pain:

(score zero of you have 'no pain' and score 10 if you have *'excruciating pain')*





Name: _____ Date: ____/____/____

NECK DISABILITY INDEX:

Instructions:

This questionnaire has been designed to give your health practitioner information as to how your neck pain has affecting your ability to manage your everyday life. Please answer by ticking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is very moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing 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 self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed e.g. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot left or carry anything at all

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I cannot read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Name: _____ Date: ____/____/____

NECK DISABILITY INDEX CONTINUED:

Section 5 – Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Section 7 – Work

- ☐ I can do as much work as I want to
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

Section 8 – Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I cannot drive my car at all

Section 9 – Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1hr sleepless)
- ☐ My sleep is mildly disturbed (1-2hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5hrs sleepless)
- ☐ My sleep is completely disturbed (5-7hrs sleepless)

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I cannot do any recreation activities at all