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:

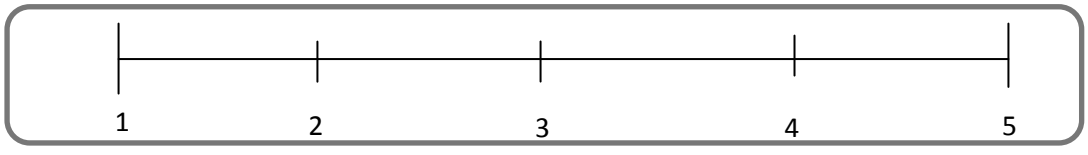
Please list any medications you are taking for your back and neck:

Please list what treatments you have had for your back and 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 back and 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)



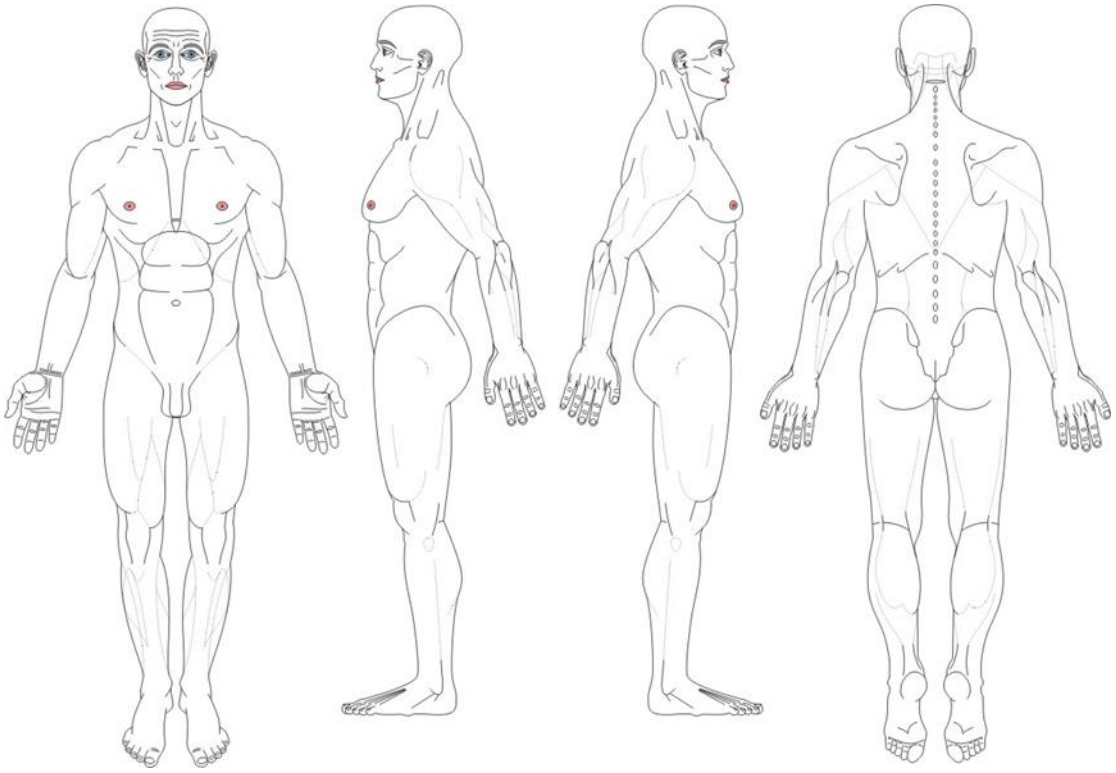
Do you have the capacity to perform light duties or a more sedentary role:

Name:_____ Date: ____/____/____

Your Pain Score – Male neck

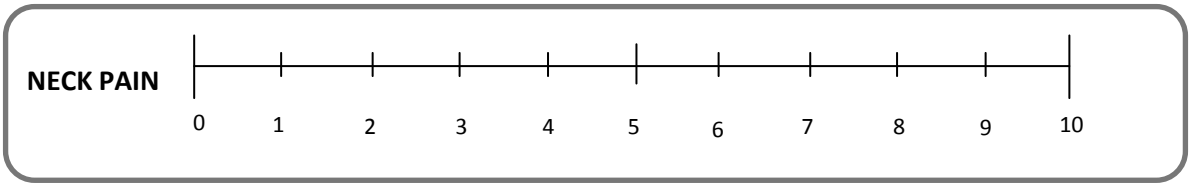
Please indicate on the schematic below the area where you feel pain in your neck:

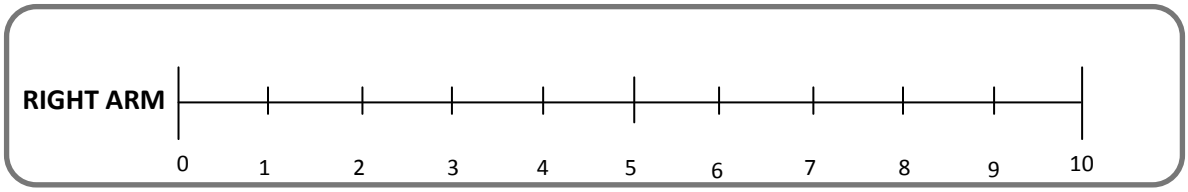
Either mark with a cross, colour or circle.



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')*



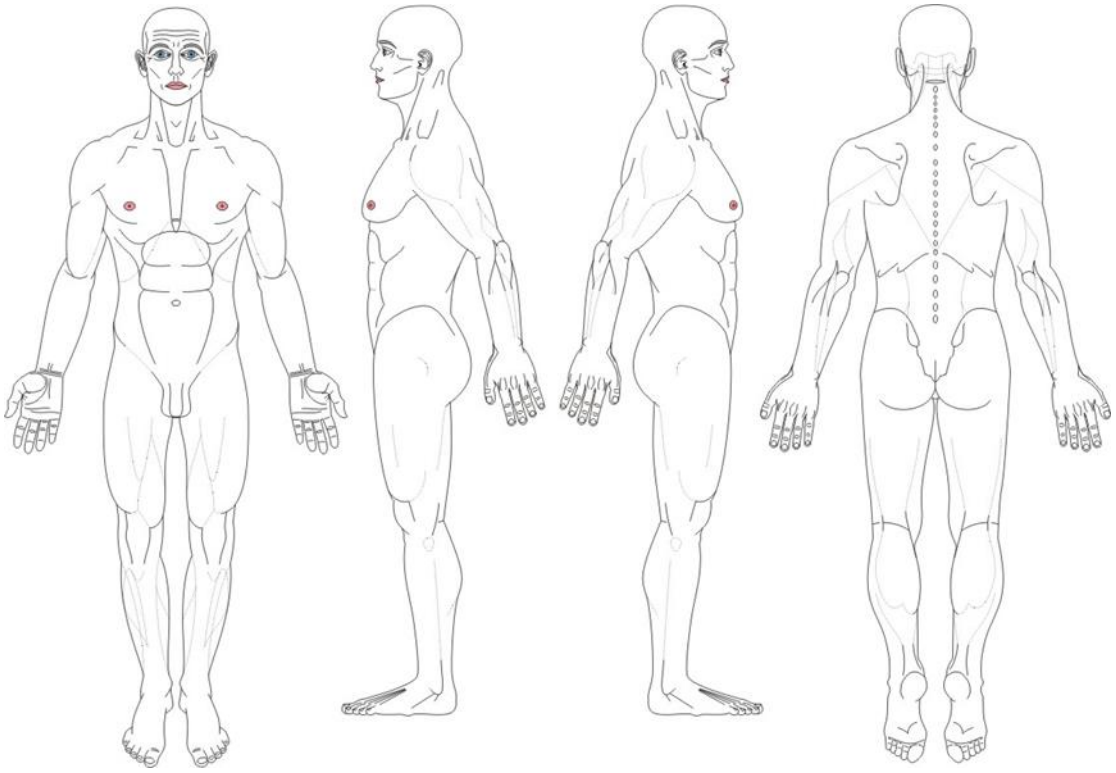


Name: _____ Date: ____/____/____

Your Pain Score – Male back

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

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')*

BACK PAIN

0 1 2 3 4 5 6 7 8 9 10

LEFT LEG

0 1 2 3 4 5 6 7 8 9 10

RIGHT LEG

0 1 2 3 4 5 6 7 8 9 10

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

Name: _____ Date: ____/____/____

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE:

Instructions:

This questionnaire has been designed to give us information as to how your back or leg pain is 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 – Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Name: _____ Date: ____/____/____

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE CONTINUED:

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than 1 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

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is normal but is very painful
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

Name: _____ Date: ____/____/____

ROLAND-MORRIS DISABILITY QUESTIONNAIRE

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today.*

As you read the list, think of yourself *today.* When you read a sentence that describes you today, put a tick in the box against it. If the sentence does not describe you, then leave the box blank and go on to the next one. Remember; only tick the sentence if you are sure it describes you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try and get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back I am not doing any of the jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back
- ☐ My back is almost is painful almost all the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back pain.
- ☐ I have trouble putting on my socks (or stockings) because of the pain in my back.
- ☐ I only walk short distances because of my back.
- ☐ I sleep less because of my back.
- ☐ Because of my back pain, I get dressed with help from someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.