LiveWell
Pain Management Clinic

New Patient Health Questionnaire

Title: *Dr Mr Ms Mrs Miss* Full Name: ____

Preferred Name: ____________________

Address: ____

____

Birth Date: ________ /________ /________ Occupation________________________________

Preferred Phone Contact: ____________________ Email: ______________________________

Emergency Contact Name: ___________Relation to you: ________ Emergency Contact Phone: ___________

Medicare Card Number: ______________________ IRN *(# next to your name)*: ________ Expiry: ______

Private Health Insurance: ________________________________Member No: ____________

GP: ______________________ Medical Practice: ______________________________

May we contact your GP regarding your treatment and progress at this clinic? **Yes / No**

How were you referred to us? (GP, Occupational Therapist, Physiotherapist, Specialist, Other)

____

Please list current medication

____

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____

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____

DVA Members:

Card Number: ______________________________

☐ Gold TPI Card ☐ Gold Card ☐ White Card; *please list conditions below:*

____

Defence Members:

EP ID: ________________ Name of On-Base Medical Officer: ______________________________

Rank: ________________ Unit: ______________

WC/ Third Party Insurer Members:

Insurer (WorkCover, QBE etc.): ____________________ Claim Number: ____________________

Case Manager / Supervisor: ____________________ Case Manager Contact Number: ______________

Case Manager email: ____

I hereby acknowledge and understand that should my claim be rejected in any way, I will be responsible for payment of accounts for any services received at LiveWell Pain Management Clinic.

I also hereby acknowledge and accept the terms outlined in the cancellation policy, which states that if I fail to cancel or reschedule an appointment without at least 24hours notice or fail to attend an appointment without any notice I may be required to pay the late cancellation/fail to attend fee.

Signature of Patient or parent guardian ______________________________

Print Patients Name ______________________________________

Date Signed ________ /________ /________

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GENERAL INFORMATION QUESTIONNAIRE

Please record the sites of your pain.

Please describe your pain. What does it feel like?

What is your average level of pain? *(please circle)*
0-3
4-7
7-10
>10

Is the pain constant OR comes and goes?

Does the pain radiate to another region?

What triggers the pain?

What makes your pain better?

What makes your pain worse?

What have you tried for pain?

ALLIED HEALTH

Are you seeing a psychologist? *If yes – provide details*

Are you seeing a physiotherapist? *If yes – provide details*

PAST MEDICAL HISTORY

Please tell us about your illnesses for which you are under regular treatment.

Please records the operations you have had in the past.

Have you seen a pain specialist before? *If yes – provide details*