WESTERN PAIN CLINIC

New Patient Form

Full Name: ____ Date of Birth: ____ / ____ / ____

Address: ____

Suburb: ____ Post Code: __________________

Home Phone: __________________________ Mobile Phone: _____________________________

Email: ____

Next of Kin Name and Phone Number: ____

General Practitioner: ____

Any other doctors that I should send letters to? ____

Medicare Number: __________________________________ Ref: ________ Expiry: ____ / _______

Health Insurance Fund: ____

*If you do not have private hospital cover, any pain procedures will be self-funded as our procedures are only performed in a private hospital.

Health Fund Card / Member Number: ______________________________________Ref: _________

Pension Card Number: ____ Expiry: ____/ ________

For Department of Veterans' Affairs

DVA Number: _____________________________________ DVA Card Colour: ☐ Gold ☐ White

DVA Condition on Card (if white): ____

For Motor Vehicle Accident or Workers Compensation Claim

Date of Accident: ___ / ___ / _____ Claim Number: ___________________________

Insurer Name: _________________________ Contact Person: __________________________

I give Western Pain staff permission to share my medical and personal information, as it relates to this workers compensation and / or motor vehicle accident claim, with the above named insurer and/or their agents.

Signed: _______________________________ Date: ____ / ____ / _________

Practice Policies

- Our Privacy Policy is available from a staff member.
- By signing this you agree to give Western Pain staff permission to obtain further information from other doctors and health professionals that have treated you and share their findings with them.
- You are liable for the full cost of all consultations and treatments, although there may be a reimbursement available from Medicare and/or your private health fund. Quotes can be provided upon request prior to any treatments (ie if you don't have insurance).
- You agree to SMS appointment reminders to be sent to the mobile number you have provided, and contact through other methods given (eg email, phone or post)
- You agree to our communication with a family member or carer acting on your behalf.

Signed: ____ Date: _____ / _____ / __________

New Patient Questionnaire

Where do you experience pain?

- ☐ Head
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Shoulder (right)
- ☐ Shoulder (left)
- ☐ Arm (right)
- ☐ Arm (left)
- ☐ Hip / Buttock (right)
- ☐ Hip / Buttock (left)
- ☐ Upper leg (right)
- ☐ Upper leg (left)
- ☐ Lower leg (right)
- ☐ Lower leg (left)
- ☐ Chest
- ☐ Abdomen
- ☐ Groin
- ☐ Other: ______________________________

Pain History – Tell us about your pain

Ie. When did it start, what does it feel like, does it radiate, what makes it worse, what makes it better, pain score out of 10, previous diagnosis

What type of imaging(s) have you had previously?

Ie. X-Ray, CT, MRI, Ultrasound, Bone Scan, Nerve Conduction Study

Which organization(s) did you have your imaging?

- ☐ SKG
- ☐ PRC (Perth Radiological Clinic)
- ☐ Western Radiology
- ☐ Envision
- ☐ I-Med
- ☐ Apex Radiology
- ☐ Other. Please specify ____

Please list ALL previous surgeries or pain interventions/injections

Please describe any other previous treatments you have tried

Ie. Physiotherapy, Hydrotherapy, Chiropractor, Occupational Therapy, TENS machine

Please list ALL your medical problems

Ie. Heart, Lung, Neurological, Gastrointestinal, Endocrine, Rheumatological, Kidneys, Liver, Urinary, Mental Health

Please list ALL the medications you are currently taking

	Medication Name	Dose	Number of tablets per day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Please list your medication allergies

What pain medications have you previously tried?

Tell us about your home situation

Ie. Who do you live with, how are you managing, home services in place, household responsibilities

Marital Status

Employment Status

Occupation

What exercises do you do regularly?

Do you drink alcohol and how much?

Do you smoke nicotine and how much?

DASS 21 Questionnaire

Read each statement and **circle a number 0, 1, 2 or 3** which indicates how much the statement **applied to you last week**.

The rating scale is as follows:
0 – Did not apply to me at all
1 – Applied to me to some degree, or some of the time
2 – Applied to me to a considerable degree or a good part of time
3 – Applied to me very much or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg. excessively rapid breathing, breathlessness without exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg. in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of exertion (ie sense of heart rate increase)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Covid-19 Questionnaire

This mandatory questionnaire is to protect the health of our patients and staff.

If your answers to the below questions change to a **Yes** prior to your appointment, please contact us immediately.

1. Are you feeling unwell with fever, cough, shortness of breath or a sore throat?	Yes	No
2. Have you been identified as a close contact of a confirmed case of Covid-19 in the past 14 days? Face-to-face contact for more than 15 minutes, or have shared an enclosed space for more than 2 hours	Yes	No
3. Have you returned from overseas within the last 14 days?	Yes	No
4. Are you waiting on Covid-19 swab results?	Yes	No
5. Have you been asked to self-isolate by your GP or a government authority?	Yes	No

If you answer Yes to any of the above questions, we will offer you a telehealth appointment, or reschedule your appointment to a later date.

THANK YOU

Please return completed forms to us prior to your appointment by either:

Email: admin@wpain.com.au
Fax: 08 6323 1888 (enter all 10 digits)
Post: Suite 14, Murdoch Clinic, SJOG Murdoch Hospital, 100 Murdoch Drive, MURDOCH WA 6150