Dr Ian D Farey MB. BS. FRACS. FAOrth.A.

Patient Registration Form

DATE: .....

WEIGHT: .....

Office Use Only

Mr/Mrs/Ms/Miss/Master/Dr/Other: _____

Family Name: _____First Name: _____ Middle Name: _____

Address: _____

Suburb: _____ Postcode: _____ Email: _____

Tel: (H): _____ (W): _____ Mobile: _____

Sex: _____ Age: _____ DOB: _____ Occupation: _____

Health Fund Name: _____ Health Fund Number: _____

Medicare No: _____ Expiry Date: _____ DVA Number: _____

REFERRING DR'S NAME: _____

REFERRING DR'S ADDRESS: _____

GP's NAME: _____

GP's ADDRESS: _____

NEXT OF KIN

NAME: _____ RELATIONSHIP: _____

Complete this box if this is a WORKERS COMPENSATION claim

Employer (if applicable): _____ Date of Injury: _____

Solicitor's Name & Address (if applicable): _____

Ins. Company Name/Address: _____

Claim No: _____ Case Manager: _____

Case Manager's Tel: _____ Case Manager's Fax: _____

CHIEF COMPLAINT: Please tick:

Do you have:	Yes	No	
Neck Pain	____	____	If more than one area, which is worse? _____
Shoulder Pain	____	____	
Arm Pain	____	____	How long have you had this problem? _____
Upper back pain	____	____	Did your symptoms follow an injury? Yes ___ No ___
Low back pain	____	____	
Hip/Leg pain	____	____	If yes: _____ at work _____ car accident _____ Other
			Please describe what happened _____

_____

Describe your pain (Tick all that apply)

Constant ____ Deep ____ Dull ____ Sharp ____ Intermittent ____ Throbbing ____

Stiffness ____ Aching ____ Shooting ____ Cramping ____ Burning ____ Stabbing ____

PREVIOUS TREATMENT:

Put a tick next to each type of treatment you have had for your current SPINAL problem.
Then tick the column that best describes the effect of the treatment.

		Did it make things					Did it make things		
Treatment	Tick if you Have had	Better	Worse	No change	Treatment	Tick if you Have had	Better	Worse	No Change
Bed Rest					Hot packs				
Pool therapy					Ice Packs				
Physiotherapy					Ultrasound				
Traction					Massage				
Medication					Yoga/Tai Chi				
Acupuncture					Braces				
Chiropractic					Splints				
TENS Machine					Biofeedback				
Spine Injection									

REVIEW OF SYSTEMS: Tick all conditions you are CURRENTLY experiencing.

Constitutional
Fever ____
Chills ____
Night Sweats ____
Weight Loss ____
Loss of appetite ____

Allergy/Immune
Drug Allergy ____
Seasonal allergy ____
Food allergy ____
Iodine allergy ____
Transplant ____

Neurologic
Paralysis ____
Tremors ____
Spasticity ____
Seizures ____
Muscle atrophy ____
Double vision ____

Musculoskeletal
Joint stiffness/swelling _____
Muscle pain/swelling ____
Muscle Fatigue ____
Fractures ____

Haemo-lymphatic
Anaemia ____
Excessive bleeding ____
Easy bruising ____
Lymphoma ____
Leukemia ____
Cancer ____
Lymph node swelling ____

CV/respiratory
Shortness of breath____
Wheezing ____
Cough ____
Coughing up blood ____
Chest pains ____
Palpitations ____
Leg swelling ____

Gastrointestinal
Difficulty swallowing ____
Heartburn ____
Nausea/vomiting ____
Constipation ____
Diarrhoea ____
Blood in stools ____
Stomach pain ____

Endocrine
Obesity _____
Thyroid disorder ____
Diabetes ____
Menopause ____
Menstrual irregularities ____
Pelvic Pain ____
Addison's disease ____

HENT	Skin/Integumentary	Psychiatric	Genitourinary
Loss of vision ____	Rash ____	Poor sleep ____	Pain urinating ____
Eye Redness ____	Ulcer ____	Depression ____	Incontinence ____
Headaches ____	Eczema ____	Anxiety ____	Blood in urine ____
Dizziness ____	Hives ____	Stress at work/home ____	Dribbling ____
Glaucoma ____	Sexual Difficulties ____		Pregnant ____

Past Surgical History:

Year **Operation** **Place Hospitalised**

_____

_____

_____

_____

If you have had PREVIOUS SPINAL SURGERY,
What were your symptoms BEFORE the surgery? Please describe:

_____

_____

Did your symptoms improve after surgery? Yes/No **If YES, how long afterwards?**
_____

Did you get worse after surgery? Yes/No **If YES, explain** _____

Were you released back to work after surgery? Yes/No If YES, when?
_____

MEDICAL HISTORY: Have you ever had.... (Tick all that apply)

____ Asthma/Breathing problems
____ Cancer
____ Radiation/Chemotherapy
____ Migraine or other severe head pain
____ High Blood Pressure
____ AIDS or HIV
____ Kidney Stones
____ Arthritis
____ Seizures

____ Phlebitis or blood clots
____ Stroke
____ Thyroid trouble
____ Kidney Infections
____ Heart Attack
____ Diabetes
____ Fibromyalgia
____ Stomach Ulcer
____ Tuberculosis
____ Hepatitis

Other current or past medical problems:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

Name of medicine/substance **Type of Reaction** **Date (if known)**

_____

_____

_____

Previous investigations and Treatment

Please list previous radiology studies you have had for your current spinal problem.

	DATE(s)		DATE(s)
MRI	_____	**Bone Mineral Density Scan**	_____
CT Scan	_____	**EMG/Nerve Conduction Studies**	_____
XRays	_____	**Bone Scan**	_____

MEDICINES: List all medicines that you take, including the doses and how often you take them. Include Vitamins and non prescription medicine.

1. _____	**5.** _____	**9.** _____
2. _____	**6.** _____	**10.** _____
3. _____	**7.** _____	**11.** _____
4. _____	**8.** _____	**12.** _____

FAMILY HISTORY: Does anyone in your family APART FROM YOU suffer from any of the following conditions?

Spinal Problems	**Yes/No**	**If yes, describe:** _____
Bleeding disorders	**Yes/No**	**If yes, describe:** _____
Heart Disease	**Yes/No**	**If yes, describe:** _____
Cancer	**Yes/No**	**If yes, describe:** _____
Diabetes	**Yes/No**	**If yes, describe:** _____

SOCIAL HISTORY:

Marital Status: **Single ____ Married ____ DeFacto ____ Divorced ____ Widowed ____ Separated ____**

Number of children? _____ **Age(s):** _____

Who lives with you at home? _____

Working status: **Working ____ Not Working ____ Homemaker ____ Student ____ Disabled ____ Retired ____**

How long have you worked at your present job? _____ **Approximate number of hours per week:** _____

Spouse's Occupation: _____

Do you currently use tobacco? **Yes/No** **Type/Amount per Day** _____ **Years smoked:** _____

Have you ever used tobacco **Yes/No** **Type/Amount per Day** _____ **Years:** _____ **If quit, when?** _____

Amount of alcohol consumed in a typical week? _____ **recreational Drug Use?** _____

Do you participate in any regular exercise? **Yes/No**

Describe: _____

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PRACTICE LOCATION
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CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signed……..... Date: .....
Patient Name: (parent / guardian if under 18 years)

Releasing Your Information to other Relatives/Friends

I give consent for Dr Farey's practice to release details regarding my treatment and/or condition to other members of my family **(please circle)** YES NO

Please list the names of people who may receive information

1. _____(Relationship to patient)_____

2. _____(Relationship to patient)_____