Pain Assessment Background Information

NORTHERN PAIN CENTRE

Dear Patient,

Welcome to Northern Pain Centre. The background information you provide in this questionnaire will help your Pain Specialist to fully assess your pain and decide which treatment pathway is best for you.

All the information Northern Pain Centre gathers from you is treated as sensitive and confidential; only authorised staff will have access to it.

Please remember to bring any doctors letters/reports and any medical imaging (e.g. x-ray, MRI) films and reports when you attend your initial consultation.

Name: .....

NORTHERN PAIN CENTRE

PATIENT CONTACT INFORMATION

Title ..... Surname ..... Given Names.....

Address: .....

..... Postcode ☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐☐☐

Telephone H ..... W.....

Mobile ..... Email .....

Medicare Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ - Ref on card ☐

Expiry Date: ☐☐☐☐☐☐

Private Health Insurance: Yes ☐ No ☐ Fund Name: .....

Membership Number: ☐☐☐☐☐☐☐☐☐☐

Department of Veteran Affairs: Yes ☐ No ☐ DVA Number: ☐☐☐☐☐☐

DVA card colour: ..... If White, for what injury: .....

Are you on a pension? Yes ☐ No ☐ Type of Pension: .....

Pension Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Pension Expiry: ☐☐/☐☐/☐☐☐☐

Is this visit related to: (tick one box)

☐ Worker's Compensation Claim

☐ Third Party Accident Compensation Claim

☐ Other Legal Case

☐ May consider claim in the future

☐ None of the above

How did you hear about the Northern Private Pain Centre?:

☐ Referring Doctor ☐ Internet ☐ Patient Forum ☐ Friend/Family

☐ Brochure/Flyer where: .....

☐ Advertisement/Interview where: .....

☐ Other Where; .....

Name of your General Practitioner:

Dr .....

Address: .....

..... Postcode: ☐☐☐☐

Telephone: ..... Fax: .....

Name of your Referring Doctor:

Dr .....

Address: .....

..... Postcode: ☐☐☐☐

Telephone: ..... Fax: .....

Is there an Insurer responsible for your accounts?

Yes ☐ No ☐

Name of the Insurance Company: .....

Address: .....

..... Postcode: ☐☐☐☐

Telephone: .....

Fax: .....

Case Manager: .....

E-mail: .....

Claim Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PRIVACY CONSENT & INFORMATION

NORTHERN PAIN CENTRE

Your doctor needs information about your past and present health in order to provide you with high quality care. This practice will make sure that you are able to discuss your health with your doctor in private.

As a healthcare provider in the private sector, we are bound by the National Privacy Act, incorporating the National Privacy Principles. The Privacy Principles set the standard by which personal information is collected, handled, used and disclosed. As a part of providing a quality healthcare service, we need to take and maintain information of a personal nature in your medical file. This information is provided by you, about you, and is handled with the utmost respect for your privacy. This may include any or all of the following information: personal details (name, address, date of birth, Medicare number), medical history, notes made during the consultation and possibly during any procedures performed, relevant reports and/or results to and from other practitioners, or results of any tests performed.

Providing your information to other doctors

The doctors in this practice respect your right to decide how your personal health information is used or disclosed (for example to other doctors). In all but exceptional circumstances, personal information that identifies you will be sent to other people only with your consent.

In this practice, it is customary for all doctors to have access to all the medical records. If you have any concerns about other doctors at this practice being able to see your records discuss your concerns with your doctor.

Similarly, it may be clinically necessary for your doctor to communicate with or obtain information from other medical professionals you have seen. If you have any concerns about communication between the Northern Pain Centre and any other health professionals you have seen please discuss this with your doctor.

Providing your information to others

With your consent the Northern Pain Centre will use and disclose your information for purposes including;

- Informing your GP and referring specialists on your treatment
- Referral to other doctors, health professionals, ordering tests and hospital admission
- Quality assurance, practice accreditation and complaint handling
- Account keeping and billing e.g Medicare, health funds, insurance companies
- Practice Management
- To meet our obligations of notification to our medical defence organisation or insurers
- To prevent or lessen a serious threat to an individual's life health or safety
- Where legally required to do so, eg notification of certain infectious diseases or suspected child abuse, or subpoena or court order
- To prevent or lessen a serious threat to an individual's life, health or safety
- If there is an overriding public health and safety interest in the release of the information.

In any of the above cases only information which is necessary to achieve the objective will be provided.

Using health information for quality improvement and research

We use patient health information to assist in improving the quality of care we give to all our patients by reviewing the treatments used in the practice.

We may also use information that does not identify you in research projects to improve health care in the community. Wherever practicable, the information used for research will not be in a form that would enable you to be identified. The publication of research results which use your information will never be in a form that enables you to be identified.

Your access to your health information

You have access to the information contained in your medical record. You may ask your doctor about any aspect of your health care including information in your record. If access is requested we ask that your request be in writing. Where you dispute the accuracy of the information you are entitled to correct that information. We will take all steps to record any of your corrections and place them with your file but will not erase the original record.

Depending on what is involved, you may be asked to contribute to the cost of providing the information.

I provide consent for the Northern Pain Centre to collect, use and disclose my personal information as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information except when legal obligations must be met. I understand that the Northern Pain Centre is not an emergency service and I will contact 000 in the case of an emergency.

Patient Name: ..... Signature: .....

Date: .....

NORTHERN PAIN CENTRE

Telehealth Client Consent Form

In addition to our general "Confidentiality and Consent Form", which includes information about confidentiality and its limits, information storage, informed consent to treatment, and consent to exchange information, we ask that you read and sign this specific Telehealth Client Informed Consent Form.

If you would like a copy of the general Confidentiality and Consent Form, please let us know.

By signing this consent form, I agree that:

I understand that the benefits of telehealth/video conferencing therapy sessions can include:

- Continued access to my doctor / allied health provider.
- Continued therapeutic support as part of my treatment plan.
- Avoiding the need for me to travel to my doctor / allied health provider.

I also understand that there are potential risks and downsides of telehealth/video conferencing therapy sessions and that these can include:

- Telehealth/video conferencing may not feel the same as face-to-face sessions.
- Technical problems could affect the video/sound quality or connection, which may disrupt the session in some ways.
- Although my doctor / allied health provider chooses video conferencing software, which has end-to-end encryption and high-security standards, there is still a small risk of hacking or others tapping into the video connection.

I understand that my doctor / allied health provider is taking the necessary precautions to ensure confidentiality, including:

- Ensuring the privacy of the telehealth session is upheld in the same way an in-person session would be, by choosing a private location or using headphones.
- Not allowing any voice or video recording of the session.

I have been informed of and understand the payment and or Medicare processes for my telehealth session, and I consent to comply with these.

I understand that I can ask questions about the telehealth session anytime.

I understand that attending a telehealth/video conferencing session is not compulsory, and I can withdraw consent at any time.

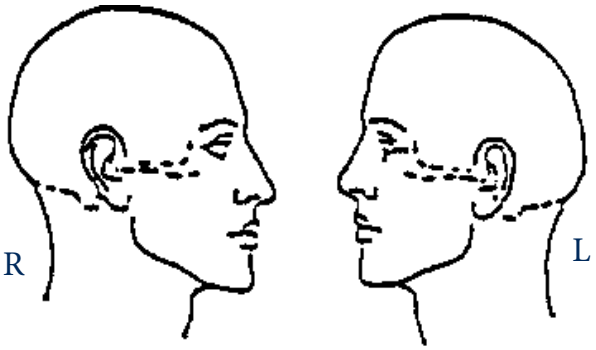
If I do not wish to continue or if technical difficulties interfere with the session to the point where we cannot continue, a phone consultation will be offered as an alternative.

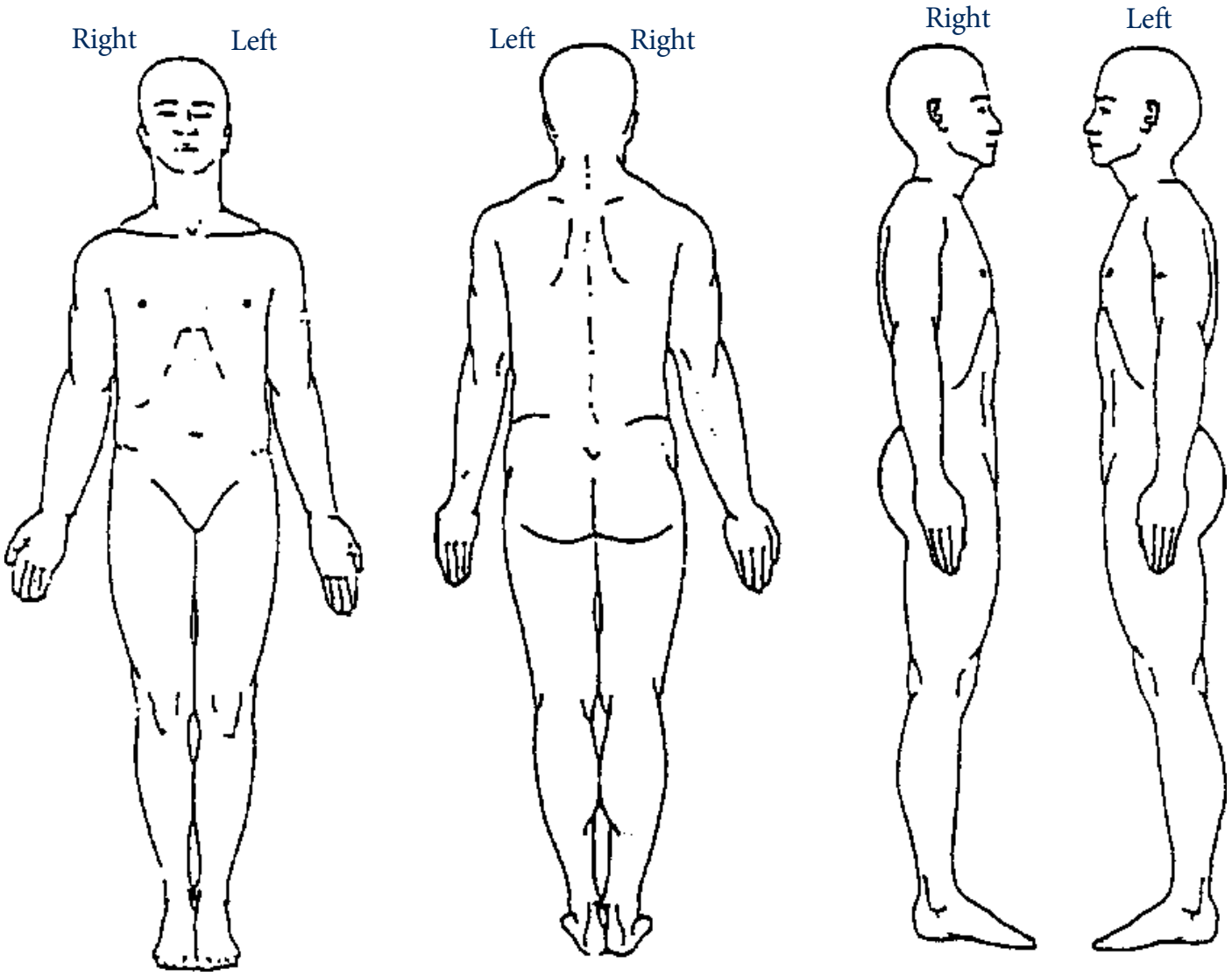
Patient Name (or Name of Parent/Carer if under 18): .....

Signature (or Signature of Parent/Carer if under 18): .....

Date: ☐☐/ ☐☐/☐☐ ☐☐

Please indicate with an X on these figures where your main pain is. Shade any area where your pain spreads. Please number (2, 3, 4, etc.) any other areas where you have pain.





How long have you had your current symptoms?

..... yrs ..... mths

Was there any precipitating injury, surgery or event?

.....

.....

.....

.....

.....

.....

Does your pain radiate anywhere?

☐ Arm ☐ Leg ☐ Groin

☐ Buttock ☐ Other .....

What words describe the nature of your pain?

☐ Sharp ☐ Dull ☐ Aching

☐ Burning ☐ Shooting ☐ Throbbing

☐ Other .....

What is the severity of your pain:

Average

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Best

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Worst

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

How does your pain vary through the day:

☐ Worst in the morning ☐ Progresses through the day

☐ Worse with activity ☐ No pattern

☐ Other .....

What makes your pain worse?

☐ Sitting ☐ Walking ☐ Stress

☐ Standing ☐ No clear reason ☐ Bending

☐ Lying down ☐ Lifting ☐ Everything

Other .....

What makes your pain better?

- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Stretching
- ☐ Relaxing
- ☐ Other (specify) .....
- ☐ Warm/hot bath
- ☐ Warm/hot shower
- ☐ Tablets
- ☐ Hot/cold packs
- ☐ Walking
- ☐ Alcohol
- ☐ Rest
- ☐ Sleep
- ☐ Nothing
- ☐ Keeping my mind off pain

Do you have any of the following symptoms:

- ☐ Urinary incontinence
- ☐ Numbness
- ☐ Unexplained weight loss
- ☐ Faecal incontinence
- ☐ Weakness
- ☐ Fever

Which specialists are involved in your case? Please provide name and contact. e.g. neurosurgeon, psychiatrist, cardiologist.

Name	Specialty

Have you had any of the following investigations

- ☐ MRI
- ☐ SPECT/Bone Scan
- ☐ CT
- ☐ X-ray

Have you had any surgery for your pain condition? Yes ☐ No ☐

Operation	Date

Have you had any injections for your pain? Yes ☐ No ☐

Please specify:

Site	Date

Have you seen a pain specialist? Yes ☐ No ☐

Have you seen any of the following: past/current

☐ Psychiatrist

☐ Psychologist

☐ Physiotherapist

☐ Chiropractor

☐ Osteopath

☐ Acupuncture

Other: .....

Please list ALL MEDICATIONS you are taking now
(include herbal medicines, vitamins and supplements, creams, gels and rubs and any use of drugs such as marijuana):

☐ I am not currently taking any medication

Medication	Dose	Route (eg. Oral, patch, cream)	How Often?	Any Side Effects?	Date Started

Do you smoke regularly? ☐ Yes ☐ No

If "yes", how many cigarettes do you smoke in a normal day .....

Do you drink alcohol regularly? ☐ Yes ☐ No

Do you ever drink alcohol to relieve your pain? ☐ Yes ☐ No

Previous Pain Medication

Medication	Dose	Route (eg. Oral, patch, cream)	How Often?	Any Side Effects?

Do you have any allergies?

Please list all other medical problems you have (for example hypertension, diabetes):

Medical condition	First diagnosed

Please list any **other** operations you have had in the past – unless listed previously

Operation	Date

Social History

Are you currently employed? ☐ Yes ☐ No

☐ On sick leave

☐ On reduced duties

What role? .....

How many hours per day? .....

How many days per week? .....

Is pain preventing you from working more? ☐ Yes ☐ No

If your pain could be reduced, but not completely, how much of a reduction would there need to be for you to feel you could live with it? ☐☐☐ %

What is your marital status? (please tick one)

☐ Married ☐ Separated

☐ De facto ☐ Widowed

☐ Divorced ☐ Single

Spouse/partner's name: .....

How many children do you have? .....

How old are your children? .....

Who do you live with (please tick one)

☐ Live alone ☐ With children only

☐ Other relatives ☐ Husband/Wife/Partner

☐ Friends/flatmates ☐ Husband/Wife/Partner & children

☐ Husband/Wife/Partner/children & extended family

Practice Locations

St Leonards
Suite 6, Level 4
North Shore Private Hospital
Westbourne Street
St Leonards 2065

Norwest
Q Central Building
Suite 107A, Level 1
10 Norbrik Drive
Bella Vista 2153

Terrey Hills
Wyvern Private Hospital
33A Myoora Road
Terrey Hills 2084

Erina
Central Coast Neurosciences
Element Building
Suite 2, Level 1
200 Central Coast Highway
Erina 2250