



SUNSHINE COAST
SPINE & ORTHOPAEDICS

Dr Greg Finch FRACS FAOrthA
Spine Surgeon | Orthopaedic Surgeon

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NEW PATIENT REGISTRATION FORM

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	Medicare Number: _____			
Card DVA Number:	Ref Number: (next to name)	Exp:		
Pension: YES NO Please Circle: Aged Disability Health Care Card	Private Health Fund: YES NO	Level of Cover:		
Pension Number: Exp:	Name of Fund:			
	Membership Number:			
Referring Doctor Details:				
In order to see Dr Finch you will need a valid referral from a medical professional.				
Referring Practitioner:				
Clinic:				
Address:				
Is your referring practitioner your regular GP? Please Circle: YES NO				
If NO, your regular GP:				
Clinic:				
Address:				

If your case is under the jurisdiction of Workcover could you please provide us with your Medicare number, Health Fund and pension details.



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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.



History...Please Tell me all about your problem (s)....was there an accident?

Have you had any treatment for your back or neck problem described above? what was it ?

Type of treatment

date or number of treatment(s)

Physiotherapy/pilates	
Spinal injections	
Spinal Surgery	
Acupuncture	
Chiropractic care	
Other	

Current Status.....How are you feeling today?

Present Work Status

Are you currently working? Y / N If no when did you last work? _____

What jobs have you had in your life?

Name of your job / profession

length of employment (years)

Have you ever had any other workers compensation or insurance claims? Y / N



If yes please describe...

Present daily Activities and hobbies eg sport? Can you do the following....

Activity	Yes	No	sort of
Play sport			
Dress yourself			
Put on shoes			
Clean the house			
Cook meals			
Do the dishes			

Is there anything else you can't do that you would like to **because of your spine?**

Family history: do any medical conditions run in the family?

Past medical history: do you have any medical conditions?

Please tick yes or no

	Yes	No
Asthma		
Diabetes		
Heart problems		
High blood pressure		
Lung problems		
Depression		
Arthritis		
Kidney problems		
Cancer of any type (now or in the past)		
If yes what type?.....		
Anything else?		

How many glasses of alcohol do you have each week??

Personal Social History:

Who is at home with you?

Do you smoke? If yes how much



List any operations you have had (if any)

Spinal surgery (Neck or lower back)	Date	place/surgeon

Any other type of surgery (eg appendix, abdominal etc..) Date	place/surgeon

Medications: Please list all your medications and dose if you can remember!!

Medication	Dose

Are you allergic to any medications Y / N
If yes please list them...

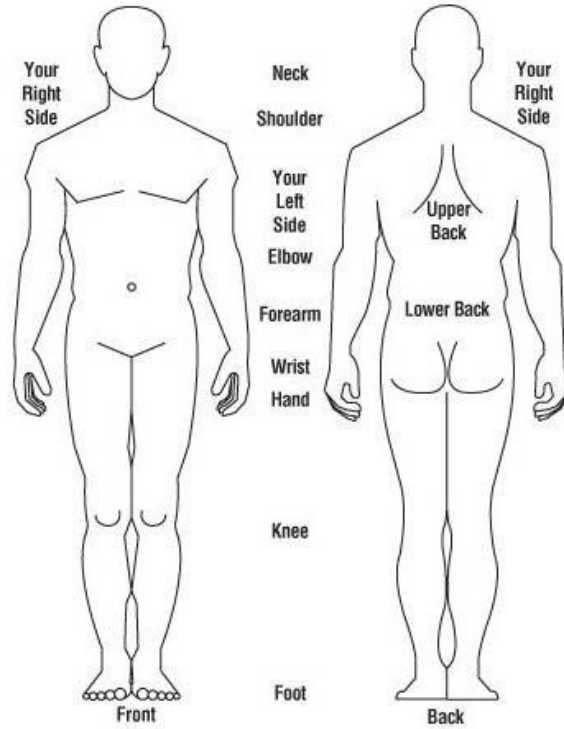
Investigations have you had any of the following tests/scans? When were they done?

Investigation	tick for yes	date (s)
X Rays		
CT Scan		
MRI Scan		
Bone Scan		
Myelogram		
Discography		
Blood tests		
Any others??		

Your Pain Score

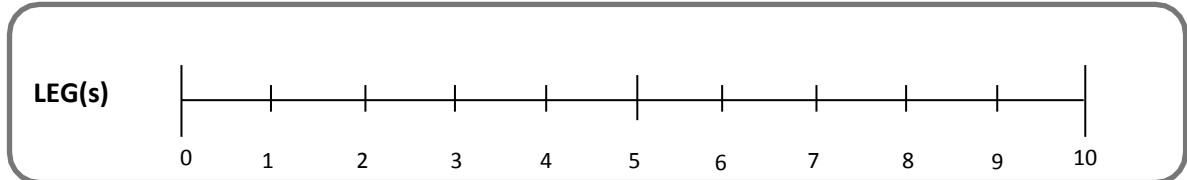
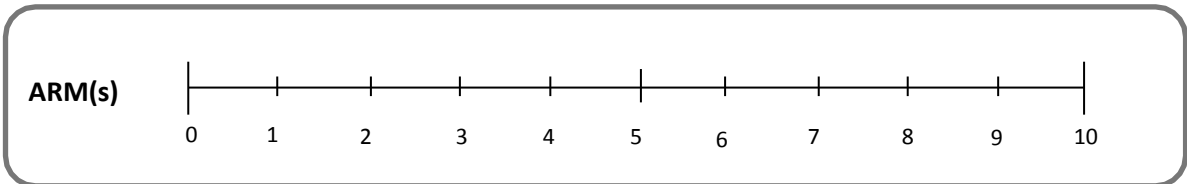
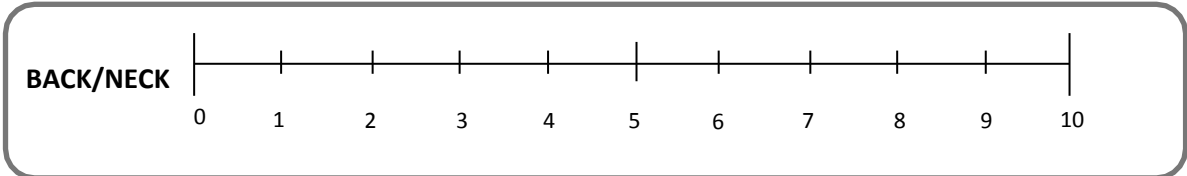
Please indicate on the picture below the area where you feel pain:

Either mark with a cross, colour or circle.



Please indicate by placing a cross on each line below the intensity of your pain:

(score zero if you have 'no pain' and score 10 if you have 'excruciating pain')



OSWESTRY 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 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 lift or carry anything at all

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 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



OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE:**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 8 – Employment/ Homemaking

- My normal homemaking/job activities do not cause pain
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
- I can perform most of my duties, but pain stops me from doing more physical activities
- Pain prevents me from doing anything but light duties
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

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 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 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 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

ROLAND-MORRIS 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.