Next Generation
Occupational Medicine

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INITIAL CONSULT QUESTIONAIRE – WORKCOVER & 3RD PARTY

Welcome to Next Generation Occupational Medicine. To make your assessment as efficient and informative as possible we ask you to please fill out the following questions about yourself:

Dr / Mr / Mrs / Ms / Miss _____

(SURNAME) (GIVEN NAMES)

Address _____ Post Code _____

Date of Birth (dd/mm/yy) _____ Age _____Email _____

Telephone (Home) _____ (Mob) _____ (Work) _____

Family Doctor's name _____Specialist's name _____

Insurer & Address _____ Claim number _____

Claims Manager's Name _____Contact number_____

Rehabilitation / Injury Management Consultant _____ Company _____

Dominant Hand _____Occupation _____

Employer name & address _____

Time with current employer _____

WorkCover and Motor Vehicle Accident claimants:

I acknowledge that I am responsible for payment of all accounts associated with treatment of my injury if my insurer or employer suspends or discontinues payment.

Signature _____

Name _____

Date ____ /____ /_____

I consent to Next Generation Occupational Medicine recording and sharing information obtained from me. I understand that this may be shared with laboratories, radiological facilities, other health service providers, rehabilitation consultants, insurers, medical defence organisations, lawyers or my employer for the purpose of investigation, treatment and rehabilitation of my injury or illness, *unless otherwise specified*. I understand that I may revoke this consent at any time in writing.

Signature _____

Name _____

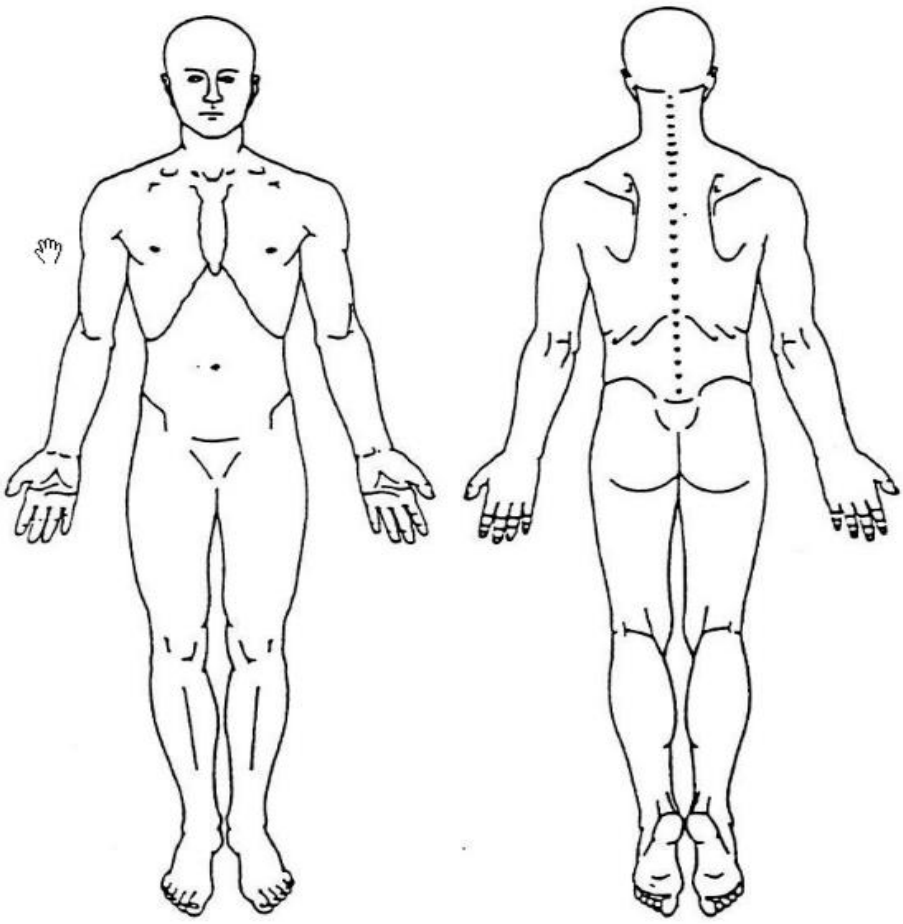
Date ____ /____ /_____

1. Date, time, and location of injury

2. Brief description of the event

3. What problems and symptoms are you currently having?

4. Description of injury or injuries (please use diagram to indicate where you feel pain – please include ALL affected areas)
Please mark on the diagram the site of pain. Also mark your worst pain with an *'x' and mark any numbness with an 'o'*



5. Investigations

Please tick (✓) if you have had the following investigations for current injury and list approximate dates.

☐ Xrays _____ ☐ CTscan_____

☐ Bone Scan_____ ☐ MRI _____

☐ Ultrasound _____ ☐ Nerve Studies _____

☐ Blood Tests_____

6. Treatment sought:

a) Current treatment for injury (please tick ✓)

Treatment type		Number of sessions				Helpfulness		
Physiotherapy	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Chiropractic	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Hydrotherapy	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Gym	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Psychology	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Acupuncture	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
TENS	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Massage	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Other	Yes ☐ No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐

b) Additional Comments:

7. Medication

Please list **ALL** medication you are **currently** taking (including those for pain) and indicate (tick box) whether or not they are helpful.

			Benefit (tick box)			
Medication	**Dose**	**Side effect**	**none**	**mild**	**moderate**	**marked**

8. Impact on daily activities i.e. home/sport/social life etc

9. What are your current working hours?

10.. What duties are you currently performing? (please include work restrictions specified by doctor)

10. What other medical conditions do you have? (please include treatment and medications)

11. Are you a smoker? Yes ☐ No☐ (if yes, please indicate how much)

12. Do you drink alcohol? Yes ☐ No☐ (if yes, please indicate how much)

13. Please list as best you can, jobs held since leaving school, including periods out of the workforce/unemployed :

Period/Year	**Job Title**	**Employer**	**Reason For Leaving**