northside physical medicine

Patient Registration

Title _____ First name _____ Last name _____

Date of Birth _____

Medicare Card No. ☐☐☐☐☐☐☐☐☐☐ Ref. No._____ Expiry ___/___
(the no. preceding your name)

Home address _____

_____

Mobile _____

Occupation _____

Any Allergies to medication?_____

Your GP's name_____Telephone _____

GP's address _____

Where appropriate, your GP may be informed about your treatment.

As most treatments involve injections please tick the box if you have any form of blood transmittable disease such as HIV or Hepatitis C Y☐ N☐

How did you hear about Northside Physical Medicine?_____

Please note that 48 hours' cancellation notice of future appointments is required. If such notice is not received, 50% of the consultation fee is payable as a cancellation fee.

Signature _____

Date _____

(Please turn over the page and fill in the pain chart. Thankyou.)

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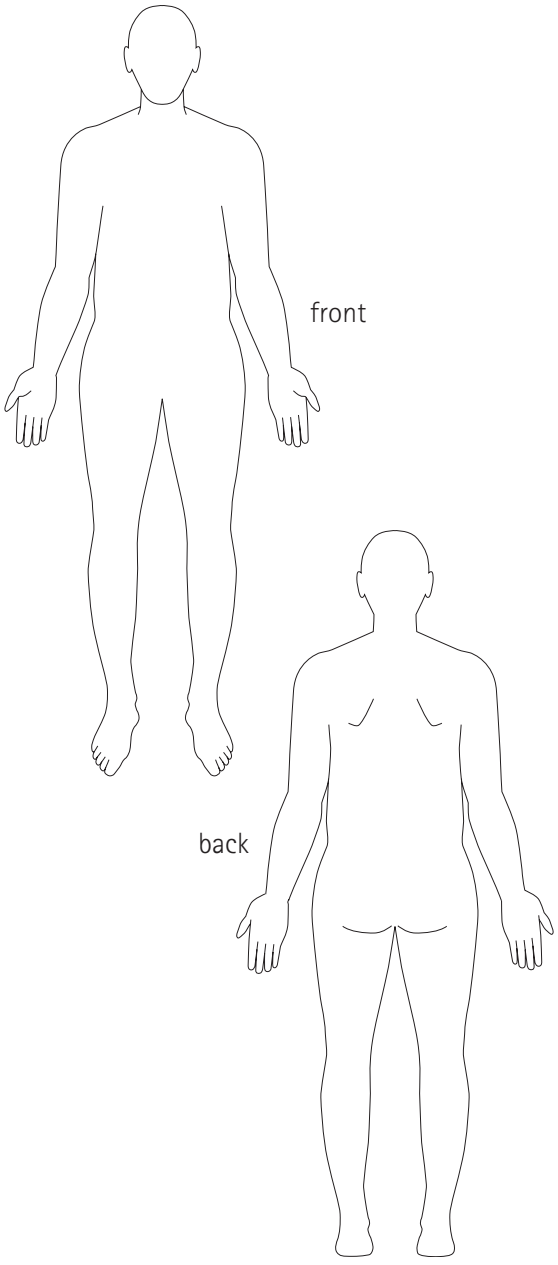
Pain chart

Personal details

Name _____ Date _____

Please draw where you feel pain on the chart below



How long have you had this pain

_____

_____

Describe your pain (eg. aching, throbbing, stabbing, shooting, tender)

_____

_____

Rate your pain on this scale at it's worst

no pain moderate pain intense pain

Rate your pain on this scale at it's best

no pain moderate pain intense pain

Rate your pain today on this scale

no pain moderate pain intense pain

How many hours of the day are you in pain?

_____

How many days per week are you in pain?

_____

How many weeks per year are you in pain?

_____

Have you taken any drugs today?
If so, what is the name of the drug and when did you take it?

_____

_____