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Patient Registration

First name _____ Last name _____

Date of Birth _____

Home address _____

Home phone _____ Work phone _____

Mobile _____

Occupation _____

Any allergies to medication? _____

Your GP's name _____ Telephone _____

GP's address _____

Where appropriate, your GP may be informed about your treatment. Please indicate your preference. Yes / No

How did you hear about Northside Physical Medicine? _____

Medicare Card No. _____ (10 digits) Ref. No. _____ Expiry / _____

Please note that 24 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.

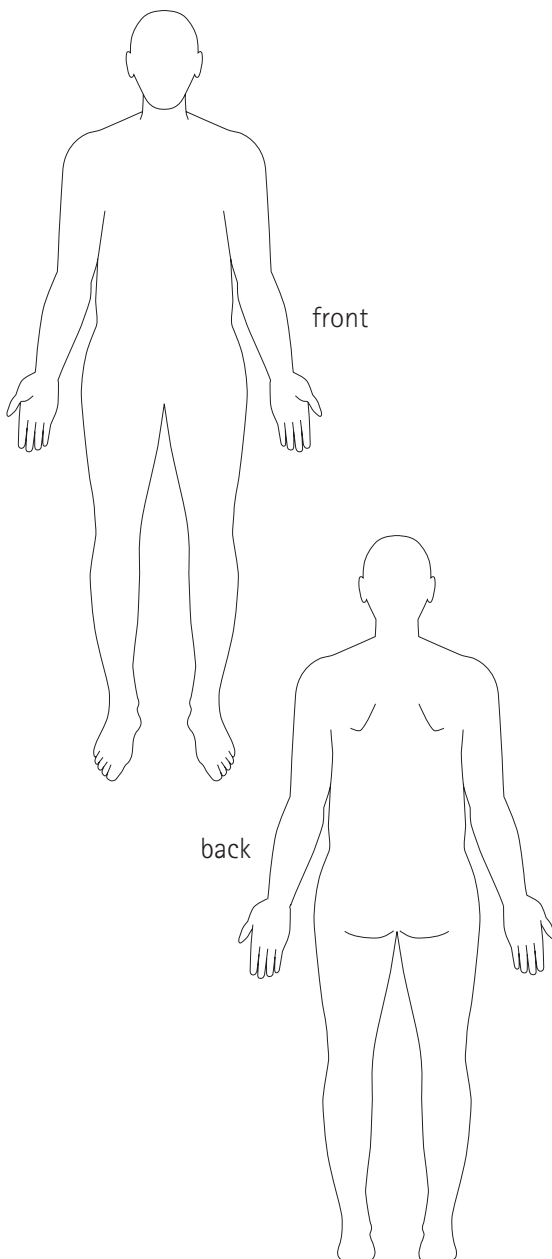
Pain chart

Personal details

Name _____

Date _____

Please draw where you feel pain on the chart below



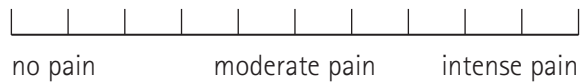
How long have you had this pain

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

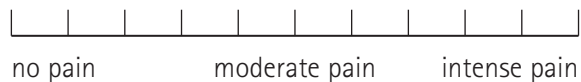
Rate your pain on this scale at it's worst



Rate your pain on this scale at it's best



Rate your pain today on this scale



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?
