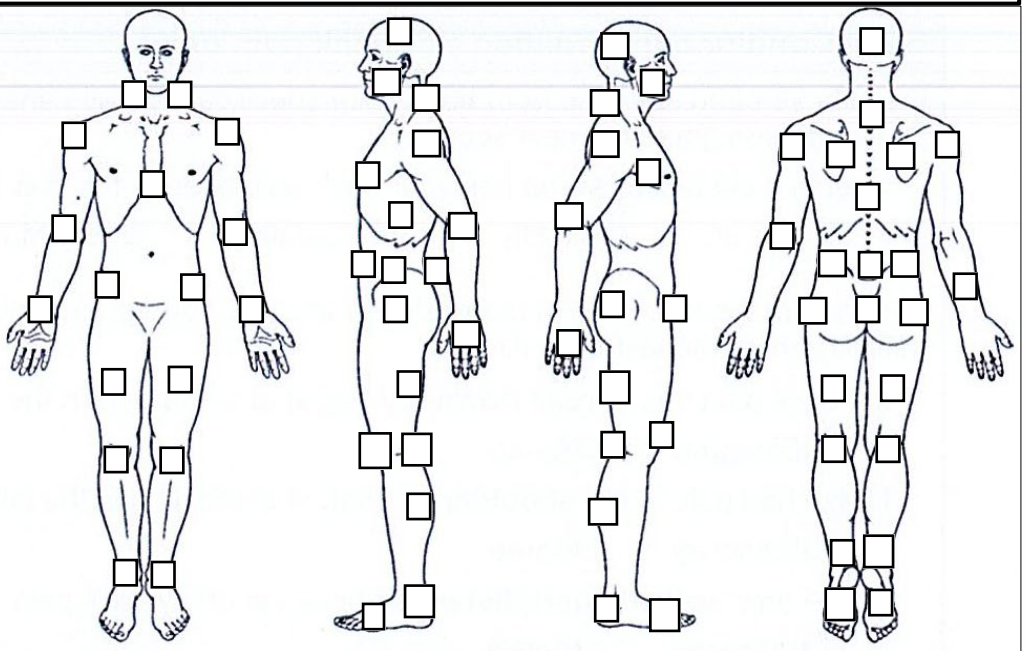
aspire
HEALTH & FUNCTION

Patient Initial Assessment

Thank you for taking a few minutes to complete the following information about your personal health. This information is important for us to be able to carry out your treatment effectively. By completing this assessment form you are consenting to this information being shared with the clinical staff caring for you. Some of it may also be used for clinical audit or administrative purposes and personal information will be anonymised wherever possible. All information will be kept confidential in line with our Data Protection Policy.

Name:	**DOB**	**Telephone:** .....
Address:		
Email:	**Health Fund:**	
Doctor:	**Doctor Ph:**	
Doctor Address:		

Please select your area(s) of pain by drawing circles on these images



Office Use Only

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Headache
- ☐ Shoulder
- ☐ Hip
- ☐ Upper Limb
- ☐ Lower Limb
- ☐ Wellness

Information about your condition:

How long has this episode of your condition lasted: .....
Have you ever had this problem before? Yes◯ No⊙ How long was last episode: .....
What does this problem stop you from doing / make harder? .....
What are your expectations / Goals for treatment of your condition? .....
.....

General information about you:

Occupation: .....
Stress Level? Low◯ Medium◯ High⊙ What do you do for stress relief? .....
How would you rate your sleep? ..... **How many hours sleep per night?**.....
Do you feel refreshed when you wake in the morning? Yes◯No⊙
Do you exercise? Yes⊙No◯How many times per week? ..... **What type?** .....
Do you Smoke? Yes◯ No⊙How many?..... **Do you Drink ? Yes◯No⊙How Many?** .....

50 Mawarra Street, Albion Q 4010
P 07 2113 3729 E admin@aspirehealthandfunction.com.au W aspirehealthandandfunction.com.au

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Pre-examination medical history information

As part of your first visit, you will be able to discuss your problem as well as any other medical issues that may be significant. In order to use the time to the best advantage, please answer the background medical questions below. Do you have or have you ever had treatment for:

Problems with circulation, blood pressure or heart	☐ Yes	☐ No
Arthritis or orthopaedic problems	☐ Yes	☐ No
Lung or breathing problems	☐ Yes	☐ No
Diqestive problems	☐ Yes	☐ No
Kidney or bladder problems	☐ Yes	☐ No
Epilepsy or neuroloqical problems	☐ Yes	☐ No
Anxiety, depression, stress or psycholoqical problems	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Cancer or tumors	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Are you currently taking any medication including contraception?	☐ Yes	☐ No
Have you ever had any operations to date?	☐ Yes	☐ No
Have you suffered any siqnificant injury as a result of an accident?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No

Additional Information:

If "Yes" was answered to any question above, please provide more information that you feel would be helpful for us to know:

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