Dr. Richard Parkinson
NEUROSURGEON

ispine NEUROSURGERY

PATIENT INFORMATION FORM

PROF / DR / MR / MRS / MS / MISS / MASTER

FIRST NAME________________________________LAST NAME ____

ADDRESS ____

SUBURB____POST CODE __________________________

DATE OF BIRTH______________________________HOME PHONE ____

WORK PHONE________________________________MOBILE PHONE ____

OCCUPATION ____

MEDICARE NO____REF_______EXP _____________________

VETERANS AFFAIRS NO _______________________________________

HEALTH FUND____________________________________MEMBERSHIP NO _________________________________

EMAIL ADDRESS ____

GP NAME ____

GP ADDRESS ____

NEXT OF KIN

FULL NAME ____

RELATIONSHIP _______________________________ PH NUMBER ____

PRIVACY ACT:

I,____AGREE TO ALLOW DR RICHARD PARKINSON ACCESS TO ALL RELEVANT INFORMATION REGARDING MY MEDICAL CONDITION. I AGREE THAT DR PARKINSON MAY BE REQUIRED TO FORWARD INFORMATION ABOUT MY MEDICAL CONDITION OR HISTORY TO OTHER HEALTH CARE PROVIDERS OR INSURERS. I UNDERSTAND THAT, TO PROVIDE THE HIGHEST MEDICAL CARE, MY CLINICAL RECORDS MAY BE ACCESSED OR REVIEWED BY STAFF AT THIS PRACTICE.

I ALSO UNDERSTAND THAT THERE MAY BE PHOTOGRAPHIC OR OTHER MEDIA TAKEN FOR A SURGICAL PROCEDURE AS REQUIRED AND I CERTIFY THAT THIS IS ALLOWED TO OCCUR WITH APPROPRIATE CONFIDENTIALITY.

SIGNED____DATED __________________________

WORKERS COMPENSATION PATIENT – PLEASE COMPLETE THE FOLLOWING

DATE OF INJURY______________________________EMPLOYER NAME ____

EMPLOYER ADDRESS ____

EMPLOYER PHONE________________________________CONTACT ____

INSURANCE CO NAME ____

INSURANCE CO ADDRESS ____

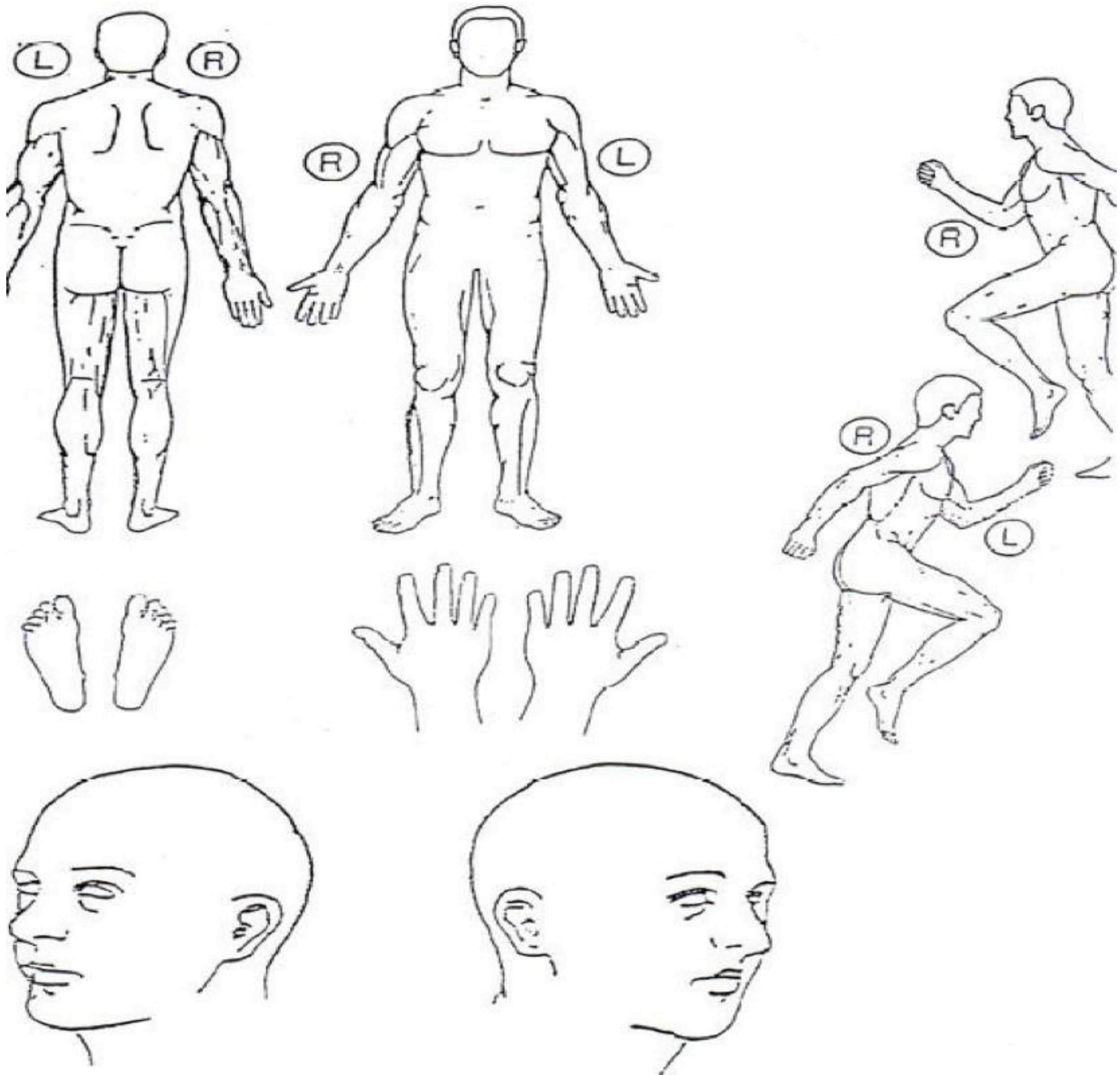
CLAIM NO____CASE MANAGER ____________________________________

SHOULD LIABILITY BE DENIED, I UNDERTAKE TO BE RESPONSIBLE FOR ANY OUTSTANDING ACCOUNTS.

SIGNED____DATED __________________________

Patient's Name: ______________________________

Please colour in painful areas black, numbness as cross hatch (xxxx):



Briefly describe your presenting problem:

____

____

____

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____

____

Indicate current level of pain on the following scale (circle):

No Pain 1 2 3 4 5 **6** **7** **8** **9** **10** **Intolerable Pain**

Please list the **medications** you are taking:

Name:	Dose:	Frequency:

Do you take **blood thinning** medications? YES / NO (eg. Asprin, Warfarin, Clopidogrel, NSAIDs)

Do you have any **allergies**? YES / NO List:

Have you ever had surgery on your **BACK** or **NECK** before? YES / NO

Have you ever had surgery on your **HEAD** or **BRAIN** before? YES / NO

List any previous surgery with dates and surgeon:

Operation:	Date:	Surgeon:

Please indicate (circle) if you suffer any of the following medical problems:

High blood pressure	Heart Attack/s	Angina	Lung problems
Diabetes Type 1 (juvenile)	Diabetes Type 2 (mature)	Heart Surgery	Heart stent
Strokes	DVT (blood clot in legs)	Kidney problems	Liver disease
HIV	Hepatitis B or C	Long standing infections	Cancer of any type
Radiotherapy	Chemotherapy	Depression	Migraine
Seizures	Gastric ulcers	Reflux	Constipation

Do you **smoke**? YES / NO How much per day? ______________________________

Do you drink **alcohol**? YES / NO How much per day? ______________________________

Do you take any **drugs** / **stimulants**? YES / NO

Are you currently receiving **treatments** by any of the following:

Physiotherapist	Chiropractor	Osteopath	Acupuncture	Herbalist
Massage therapy	Hydrotherapy	Traction	Other: ______________	

SF–8™ Health Survey

This survey asks for your view about your health. Please **circle** your response.

1. Overall, how would you **rate your health** during the past 4 weeks?

Excellent　Very good　Good　Fair　Poor　Very poor

2. During the past 4 weeks, how much did **physical health problems** limit your usual physical activities (such as walking or climbing stairs)?

Not at all　Very little　Somewhat　Quite a lot　Could not do physical activities

3. During the past 4 weeks, how much difficulty did you have doing your **daily work**, both at home and away from home, because of your physical health?

None at all　A little bit　Some　Quite a lot　Could not do daily work

4. How much **bodily pain** have you had during the past 4 weeks?

None　Very mild　Mild　Moderate　Severe　Very severe

5. During the past 4 weeks, how much **energy** did you have?

Very much　Quite a lot　Some　A little　None

6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual **social activities** with family or friends?

Not at all　Very little　Somewhat　Quite a lot　Could not do social activities

7. During the past 4 weeks, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?

Not at all　Slightly　Moderately　Quite a lot　Extremely

8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your **usual work**, school or other daily activities?

Not at all　Very little　Somewhat　Quite a lot　Could not do daily activities

Is there any other **information about yourself** that you would like us to know?

____

____

____

List any **doctors** you are seeing with address and contact details:

____

____

____

Are there any **other health care providers** (say, physic or chiro) that you would like correspondence to be sent to?

____

____

____

What are the **main questions** you would like answered today (eg. why am I in pain?, what are my options for treatment?, will this get better by itself?, what are the risks of surgery?, should I see anyone else about this problem?)?

1. ____
2. ____
3. ____

PLEASE EMAIL OR FAX THE FOLLOWING AS SOON AS POSSIBLE

1. Completed Patient Information Form (this document)
2. Referral Letter
3. MRI & CT Report(s)
4. Workers Compensation Patient – Approval to be Consulted by Dr Richard Parkinson

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PHONE: +61 2 8382 6470

ADDRESS: Suite 402 (on Ground Level)

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