BRAIN REHABILATATION

Adult Questionnaire

It is our pleasure to welcome you to Brainstorm Rehabilitation. Please complete the following questionnaire. Your answers will help us to determine whether we can help you. This Comprehensive examination is part one of your thorough interview procedure. Included with this consultation will be a "conference report" appointment the following week. Please note this information is strictly confidential and will help the practice provide better care for you. ***Thank you.***

PART A

YOUR DETAILS

Name: Mr/Mrs/Mstr/Miss/Ms/Dr ______________________________

First *MI* *Surname*

Gender: ☐ Male ☐ Female Date of birth: ___/___/___

Address: ______________________________

Street # *Street Name* *Suburb* *PCode*

Postal Address: ______________________________

☐ *As Above* *Street #* *Street Name* *Suburb* *PCode*

Contact details:

Home PH: ______________

Mobile PH: ______________

Work PH: ______________

E-mail: ______________________________

Preferred method of contact number:

☐ home

☐ mobile

☐ work

Are you a member of a private health fund?

☐ No ☐ Yes - Fund Name:______________________________

Occupation:______________________________

If retired or unemployed, your previous occupation: ______________________________

Name(s) of other Family members (s) :	Age (s) :

OFFICIAL USE:

Name..................................

File Number.......................

We appreciate Referrals. How did you find out about our clinic?

- ☐ Friend, please specify: ____________________
- ☐ Family member
- ☐ Yellow Pages
- ☐ Other (please specify): ____________________
- ☐ Another Health Professional
- ☐ Our Signage

PART B

People present to our clinic with various health concerns or complaints. What is your major presenting problem that we may assist you with?

Personal Medical History:

Please list all **operation and hospitalisations, falls and injuries** and **serious or chronic illnesses:**

Year	Problem
Year	Problem
Year	Problem
Year	Problem
Year	Problem
Year	Problem

Have you suffered from:

Heart/Blood Vessel disease:	Yes	No	Date	Diabetes:	Yes	No	Date
High blood pressure:	Yes	No	Date	Strokes:	Yes	No	Date
Asthma/Eczema:	Yes	No	Date	Cancer:	Yes	No	Date

Are you currently seeing a GP or Specialist?

Do you suffer from any of the following:

Unexplained fevers	Yes	No	Unexplained weight loss	Yes	No
Night Sweats	Yes	No	Do you to wake at night because of pain (s)?	Yes	No
Abnormal bleeding	Yes	No			

Have any of your relatives suffered from:

Diabetes	Cancer
Heart/ Blood Vessel diseases	Strokes
Epilepsy	Nervous System Illness
Muscle, bone or joint problems	

Do you drink? Yes No Amount units/week Do you smoke? Yes No Amount /day

Drug/ Medication Names	*Dosage*	*Reasons for use*

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Name.................................

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Context of Care Information

This helps us understand your health goals and how they fit in with your care.

1. What are your health and lifestyle goals?

____

____

2. List your top three priorities in life. Where do health and vitality fit in?

   i.____

   ii.____

   iii.____

3. How do you rate your present level of health? *Rate 1-10. 10 being excellent.* ( )
4. How do you rate your present level of vitality? *Rate 1-10. 10 being excellent.* ( )

5. How confident are you in your ability to persevere with the healthy diet, lifestyle and exercise programs required for you to achieve health and wellbeing?

   a. Rate 1-10. 10 being highly confident. ( )

6. How committed are you to improving your health status?

   a. Rate 1-10. 10 being highly committed. ( )

7. Are you willing to change your diet?

   Yes ( ) No ( ) Maybe ( )

   Explain

8. Are you willing to change your lifestyle habits?

   Yes ( ) No ( ) Maybe ( )

   Explain

9. Are you willing to increase your strength and stamina with a strength resistance program?

   Yes ( ) No ( ) Maybe ( )

   Explain

10. How long do you feel it would take you to achieve your health and lifestyle goals?

    Days ( ) Weeks ( ) Months ( ) Years ( )

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Name.................................

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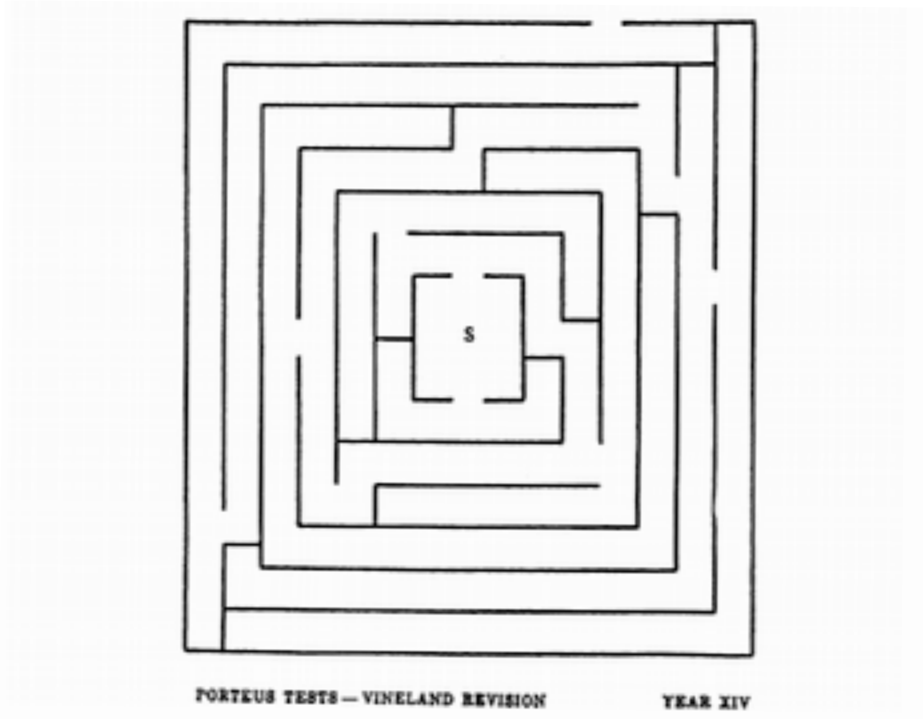
Complete the following activities in the space provided below and on the back of this page.

1. **Complete the maze**
2. **Draw a clock face with all the numbers and hands displaying '10 to 11' in the space below.**
3. **Draw a house**



PLEASE NOTE:
This section will be completed in the centre.

OFFICIAL USE:
Name.................................
File Number......................

PART E

Do you have any problems with the following?	*Now? (Please tick)*	*In the past? (Please tick)*	*R = Right side L = Left side B = Both sides*
Tremors or uncontrollable movements of the arms, legs or body			
Stiffness, cramping, or twitching anywhere			
Weakness anywhere			
Wasting of muscles			
Dizziness, vertigo or travel sickness			
Co-ordination difficulties			
Pain in the head, jaw, eye or ear			
Ringing, fullness in the ears or altered hearing			
Unusual sensations anywhere (e.g. tingling, numbness, coldness etc.)			
Experience altered skin sensitivity			
Dryness of the mouth or eyes			
Increased tearing from one or both eyes			
Changes in sweating on either side of the body			
Coldness or puffiness in the extremities			
Dizziness or light-headedness when standing up quickly			
Fluctuations in heart rate or rhythm			
Breathing difficulties			
Altered digestion or bowel movements			
Ulcers or irritability in the stomach or bowel. Starting or stopping urine flow			
Maintaining steady urine flow			
Sexual dysfunction			
Sleeping difficulties			
Mental arithmetic (maths)			
Decision making, planning or organisation skills			
Maintaining attention or concentration			
Behaviour, mood or personality			
Expression of thoughts or words			
Understanding speech or the written word			
Recognising people or objects			
Orientation or spatial awareness (eg map reading etc.)			
Short or long-term memory			
Anxiety or fear			
Seizures, anxiety or panic attacks			
Depression			
Confusing your left and right			

Official Use: Additional forms. ADI/ VAS/ GPCOD/ Balance Battery

OFFICIAL USE:
Name..................................
File Number......................

Patient Consent Form.

I consent to undergoing an examination to determine the cause of the condition for which I have attended the clinic. The examination may entail photographic or video recordings for inclusion in my records. Further consent will be obtained for any treatment after the examination and an explanation of the findings.

Signed:___________________________________ Dated__________________

I accept financial responsibility for my consultations and treatment. Fees are due at the time of visit unless agreed in advance. Unauthorised late payments will attract fees and interest, details of which are available on request. Insurance policies are an agreement between the insurer and myself, and I am responsible for any fees I am unable to claim through a policy. I remain responsible for any fees that the Clinic is unable to recover through these schemes.

Twelve hours notice of cancellation of appointments is required or the full fee for the appointment will be due. The Clinic may waive any of the above on occasions. If the Clinic does so it reserves the right to enforce the agreement at a later date.

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between providers within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

I understand that the practice supports the expansion of clinical knowledge and expertise. One of the ways it does this is by using clinical information for education, and scientific and case studies. All identifying information is removed from any data before it is used. I consent for my information to be used in this manner. I understand I may remove this consent at any stage without compromising my care in any way.

Signed:_________________________________Dated:_________________________

PLEASE NOTE:
This section will be completed in the centre.

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