GPS² Patient Intake Form
Physical Injuries

Welcome to GPS². We ask that you please take some time to complete this form to the best of your knowledge. If it would help, please feel free to complete this Form with your General Practitioner. The Form will allow the GPS² Specialist to get to know more about you and your medical condition(s), in order to provide medical advice and prepare a report for your General Practitioner.

We ask that you please complete this form **prior to** your appointment and bring it with you on the date of the appointment, so there will be no delay when you arrive. If you forget to bring it with you, we will ask you to complete the Form on arrival.

The contents of this Form are confidential and will be kept as part of your medical records. If you have any questions about confidentially or completing any aspects of the form, please contact us for clarification on 1800 477 246.

Date of Appointment:	Date Form Completed:	Date of Birth:
Name:		
Address:		
Phone:	Height:	Weight:
Marital Status:	Dependent Children:	
Highest Level of Education:		
General Practitioner's Name:		
General Practitioner's Address:		

Smoker?	☐ Yes	☐ No (tick one)	Amount per week:
Drink Alcohol?	☐ Yes	☐ No (tick one)	Amount per week:
Take Recreational Drugs?	☐ Yes	☐ No (tick one)	Amount per week:

WORK HISTORY	
Are you presently working? ☐ Yes ☐ No (please tick)	If no, when did you cease work?
Whom do you work for (company name)?	
Are you currently working: Full time:.....(hours) or Part time:.....(hours and days)	
Are you working normal duties? ☐ Yes ☐ No	Are you working modified or alternative duties? ☐ Yes ☐ No
Work Restrictions (please specify):	

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General Practitioner's Specialist Service
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GPS² Patient Intake Form
Physical Injuries

PAST MEDICAL HISTORY

My general state of health is:

Please address the following:
Current Work-related Injuries (specify body areas and any diagnoses given):

Prior Injuries/illnesses (please list):

Surgeries:

Allergies:

Do you do any exercise for fitness: ☐ Yes ☐ No
If Yes, describe workout and frequency:

Do you have any problems with any of the following:

Heart	☐ Yes	☐ No	Digestive System	☐ Yes	☐ No
Lungs	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Kidneys	☐ Yes	☐ No	Migraines/Headaches	☐ Yes	☐ No
Psychiatric Conditions	☐ Yes	☐ No			

Other health issues: (please specify)

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General Practitioner's Specialist Service
Navigating Treatment Pathways

GPS² Patient Intake Form
Physical Injuries

History of Current Illness: Occupation at the time of illness:	
Emplpoyer at time of illness:	
How long employed by that company?	Date of injury:
What happened?	
Describe all initial complaints and body part(s) involved:	
What did you do immediately after the injury:	
How was it later in the day:	
How was it the next day:	
When did you first seek medical attention:	
From whom:	
What other medical practitioners have you consulted:	

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General Practitioner's Specialist Service
Navigating Treatment Pathways

GPS² Patient Intake Form
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Have you had:

X-Rays	☐ Yes	☐ No	CT Scan	☐ Yes	☐ No
MRI	☐ Yes	☐ No	EMG	☐ Yes	☐ No
Ultrasound	☐ Yes	☐ No	ECG	☐ Yes	☐ No

Other tests: (please specify)

Have you been hospitalised because of your illness: ☐ Yes ☐ No
If yes, please provide circumstances and dates:

What treatments have you had so far as a result of this injury? Please also provide frequency of treatment and name of the treatment provider(s):

Are you using any medical devices or aids for your condition? If yes, please specify the type of aid/device:

Please describe your current activities of daily living (what do you do to cope with your illness):

What are your treatment goals:

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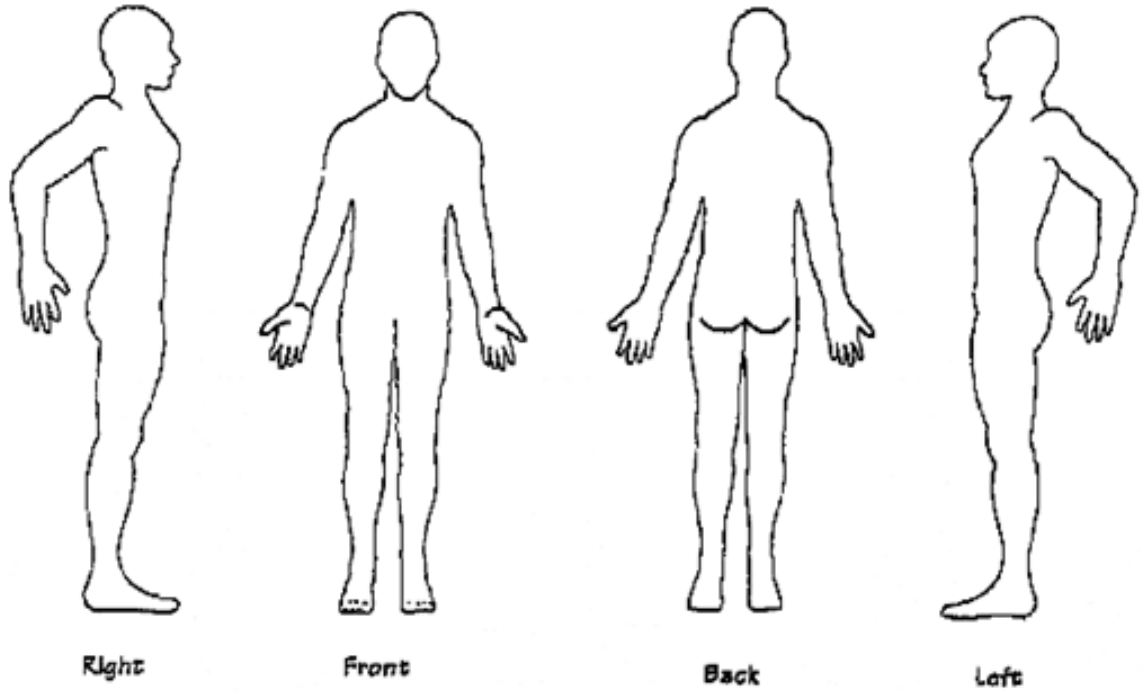
GPS² Patient Intake Form
Physical Injuries

What are your return to work goals:

Pain Drawing

Please fill out as accurately as possible. This will help the Specialist to better understand where you are hurting. Using the symbols given below, please mark the areas on your body where you feel the described sensations. Include all affected areas. If these sensations are spreading to other areas, use arrows to show where and in what direction.

1. Numbness	II II II II	2. Pins & Needles	0 0 0 0	3. Burning	xxxxxx
4 Stabbing	>>>>>	5. Aching	//////////		



My current pain level on a scale of 0 to 10, with 0 being pain free and 10 being in excruciating pain constantly, where would you rate your pain intensity?

1 2 3 4 5 6 7 8 9 10

My pain is: ( ) increasing ( ) decreasing ( ) Staying the same

Patient Signature:

Date:

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