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Auckland Spinal Rehabilitation Unit

Health Questionnaire

Date: _____

To keep our  records accurate, please fill in the boxes below

Name:		
Correspondence Address:		
Telephone No:		Mobile:
Email:		
NHI:		
ACC No:		
ACC Coordinator details:		
GP Name & Medical Centre:		

Please answer all the following questions:

1. In the last 12 months have you had any admissions to hospital?

 ☐ No  ☐ Yes

If yes, what was the admission or admissions for?

Please tick if you have any issues or concerns with the following:

☐ Bladder or Catheter issues	☐ Chest / Respiratory / Frequent Colds / Flu
☐ Bladder infections / UTI's	☐ Mobility / Transfers
☐ Bowel	☐ Recreation or Sport
☐ Skin	☐ Weight / Nutrition / Diet
☐ Medications	☐ Wheelchair & Seating
☐ Spasms	☐ Other Equipment
☐ Pain	☐ Employment
☐ Intimacy, Sex & Fertility	☐ Community Access or Transport
☐ Sleep	☐ Emotional Wellbeing / Mood
☐ Decrease in Strength or Function	☐ Housing Modifications
☐ Alcohol & Drug Overuse	☐ Other: _____

Please describe your concern or issues in more detail:

Circle how important it is that these issues or concerns are addressed?

Not important 1 2 3 4 5 6 7 8 9 10 Very important

Circle your willingness to alter your lifestyle / routine to address these issues?

Not willing at all 1 2 3 4 5 6 7 8 9 10 Very willing

What is your preferred <u>day & time</u> that we can call you to discuss this form?

Preferred day: _____ and time: _____

Preferred contact no: _____

Thank you