**Initial - Self Reporting Questionnaire**

Your Health Care Practitioner has asked that you complete an SRQ (Self Reporting Questionnaire). An SRQ enables the practitioner to assess your capabilities and also gives them vital information that is required in reports that need to be submitted to your insurance company for a review.

***There are 2 steps to this questionnaire, firstly please complete the Section One please base your answers on pre work place injury, Section Two answers are to be based on your post work place pre injury.***

***How to complete this form:*** *In order to fill out this questionnaire, make sure that you are able to edit the document, you may need to download it into word.*

*To select your answers, click on the wording in RED, this will them bring up a drop down arrow, Click on the dropdown arrow and make your selection.*

*Once the form is completed, please return via email to* [*info@enrichedhealthcare.com.au*](mailto:info@enrichedhealthcare.com.au) *or fax 02 5524 7002.*

*If you have any questions regarding the questionnaire, please do not hesitate to contact our practice on 02 6583 6900.*

**NAME: DATE:**

**Section One: Pre Work Place Injury**

Please complete the following based upon what **you were** able to do *pre injury*

**Current Self-Reported Pain**

*In the last week where 0= no pain and 10 = extreme pain how would you rate your pain?*

At its best out of 10:    Best out of 10

At its worst out of 10:     Worst out of 10

**Any Easing factors?**

**Any aggravating factors?**

**Self-reported tolerances**

*Please provide comment on your tolerances for the following*

|  |  |  |  |
| --- | --- | --- | --- |
| Sitting | Minutes (mins) | Lifting | Kgs (kgs) |
| Walking | Minutes (mins) | Carrying | Kgs (kgs) |
| Static Standing | Minutes (mins) | Pushing | Kgs (kgs) |
| Dynamic Standing | Minutes (mins) | Pulling | Kgs (kgs) |

**Self-reported restrictions**

***Please provide comment on any current physical restrictions due to your compensable injury***

**Activities of Daily Living**

*Please provide comment on your ADLs. (No restriction, slight restriction, significant restriction, total restriction, not applicable.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Bed Making | Restrictions | Cooking | Restrictions |
| Child Care | Restrictions | Gardening | Restrictions |
| Cleaning | Restrictions | Transfers | Restrictions |
| Self-Care | Restrictions | Vacuuming | Restrictions |
| Shopping | Restrictions | Ironing | Restrictions |
| Other | Restrictions | Washing | Restrictions |

**Work Status**

|  |  |
| --- | --- |
| Are you currently working | Work Status |
| If Yes, how many hours per day | Hours per day |
| How many days per week | Days per week |

***Goals:***

**MEDICATION**

Please list any medications that you are currently taking/prescribed.

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Times per day** |
|  |  |  |
|  |  |  |
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|  |  |  |
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**Initial - Self Reporting Questionnaire - Continued**

***Section Two: Post Work Place Injury***

Please complete the following based upon what **are able to do now** since the injury

**Current Self-Reported Pain**

*In the last week where 0= no pain and 10 = extreme pain how would you rate your pain?*

At its best out of 10:    Best out of 10

At its worst out of 10:     Worst out of 10

**Any Easing factors?**

**Any aggravating factors?**

**Self-reported tolerances**

*Please provide comment on your tolerances for the following*

|  |  |  |  |
| --- | --- | --- | --- |
| Sitting | Minutes (mins) | Lifting | Kgs (kgs) |
| Walking | Minutes (mins) | Carrying | Kgs (kgs) |
| Static Standing | Minutes (mins) | Pushing | Kgs (kgs) |
| Dynamic Standing | Minutes (mins) | Pulling | Kgs (kgs) |

**Self-reported restrictions**

***Please provide comment on any current physical restrictions due to your compensable injury***

**Activities of Daily Living**

*Please provide comment on your ADLs. (No restriction, slight restriction, significant restriction, total restriction, not applicable.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Bed Making | Restrictions | Cooking | Restrictions |
| Child Care | Restrictions | Gardening | Restrictions |
| Cleaning | Restrictions | Transfers | Restrictions |
| Self-Care | Restrictions | Vacuuming | Restrictions |
| Shopping | Restrictions | Ironing | Restrictions |
| Other | Restrictions | Washing | Restrictions |

**Work Status**

|  |  |
| --- | --- |
| Are you currently working | Work Status |
| If Yes, how many hours per day | Hours per day |
| How many days per week | Days per week |

***Goals:***

**MEDICATION**

Please list any medications that you are currently taking/prescribed.

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Times per day |
|  |  |  |
|  |  |  |
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