SPINAL OUTREACH SERVICE HEALTH QUESTIONNAIRE (SOS-HQ)

CLIENT DETAILS

Surname:	**Given Names:**
DOB:	**Medicare Number:**

Address:

Style of accommodation: ☐ Dept. of Housing ☐ Rented ☐ Own home
Living: ☐ Alone ☐ With family/spouse ☐ With friends/other

Phone: H: ( ) _____ W: ( ) _____ M: _____	COB: Preferred Language:

SPINAL DIAGNOSIS

Date of Injury:	Cause:
Level of Injury:	ASIA Score:
Hospital of Acute Admission:	Spinal Specialist:

Other injuries sustained at time of accident other than SCI? ☐ Yes ☐ No If Yes, please state

Hospital Admissions/Review by specialist dates

Medical History

Current Medications

10. Musculoskeletal Function

PATIENT SECTION	GP/NURSE SECTION
10.1. Have you noticed any significant change in your posture, increased curvature of the spine and/or difficulty in maintaining an upright seating position (e.g. Leaning to one side, hooking over backrest or slumping forward)? ☐ Yes ☐ No Details _____ _____	Examination
10.2 Do you suffer from pain in the upper limbs with activities? ☐ Yes ☐ No If yes, how often? ☐Never ☐ Sometimes ☐ Often ☐ Always Is the pain present at rest (e.g. lying in bed)? ☐ Yes ☐ No Where do you get the most pain? ☐ Shoulders: left or right ☐ Elbows: left or right ☐ Wrists: left or right ☐ Hands: Left or Right ☐ Other: _____	
10.3 What activities aggravate the pain? ☐ Pushing wheelchair ☐ Dressing/other ADL ☐ Sports/Recreation ☐ Transfers ☐ Computers/Work ☐ Driving ☐ Lifting for pressure relief ☐ Standing/walking with aids ☐ Other_____ Details _____ _____	
10.4 Do you stop activity when the pain develops? ☐ Yes ☐ No	
10.5 Did you suffer any injury and/or have any pain in the upper limbs prior to the spinal cord injury? ☐ Yes ☐ No If Yes, details _____ _____	
10.6 Have you had any fractures (broken bones) from falling from standing height or from low impact accidents? ☐ Yes ☐ No If Yes, when and which bone was broken? _____ _____	Does the person need: ☐ Osteoporosis work up ☐ DEXA scan/Calcaneal ultrasound ☐ Referral to endocrinologist ☐ Treatment for osteoporosis

11. General Health

PATIENT SECTION	GP/NURSE SECTION
11.1 Do you have more than 4 (if male) or more than 2 (if female) servings of alcohol almost every day? ☐ Yes ☐ No	☐ CAGE questionnaire
11.2 If female and aged 18-70, when was your last Pap smear?_____ If female and aged 50-69, when was your last mammogram? _____	Previous results available for review? _____ ☐ Organise Pap smear ☐ Organise mammogram

11.3 Please tick the box that best describes the amount of time you feel for each question.

In the last 4 weeks, How often did you:	**Never/a little of the time**	**Some of the time**	**Most of the time**
Feel tired or lacking energy for no good reason?	☐	☐	☐
Feel depressed, hopeless or worthless?	☐	☐	☐
Feel that everything was an effort?	☐	☐	☐
Feel nervous, tense, worried or panicked?	☐	☐	☐
Have difficulty falling or staying asleep?	☐	☐	☐

Have you:

Lost interest or pleasure in most of your usual activities? ☐ Yes ☐ No

Lost your appetite or are overeating? ☐ Yes ☐ No

Had recurrent thoughts of death? ☐ Yes ☐ No

Describe: _____

_____

11.4 Are you satisfied with the level of care you currently receive for:

Activities of Daily Living? (eg Showering, Feeding) ☐ Yes ☐ No

Domestic tasks (eg Meal Prep, Laundry, Home maintenance) ☐ Yes ☐ No

Clinical care (catheter changes, wound care, home visits) ☐ Yes ☐ No

Does person need:
☐ Review of care needs with relevant care provider?
☐ Referral to social worker?
☐ Referral to Community Nurse?

11.5 How are you getting around at the moment?

☐ Not able to get out ☐ Wheelchair only ☐ Driving Self

☐ Carer / Other Drives ☐ Other service provider transport

☐ Taxi ☐ Bus ☐ Train

Are there any new difficulties/issues? _____

11.6 Are you currently employed? ☐ Yes ☐ No

If Yes, does your workplace adequately suit your needs?

Describe:

If No, would you like to return to work/study? ☐ Yes ☐ No

☐ Referral to occupational therapist

☐ Referral to Commonwealth Rehabilitation Service (CRS)

12. Sexual Function

PATIENT SECTION	GP/NURSE SECTION
12.1 Do you have a satisfying sexual relationship? ☐ Yes ☐ No	
12.2 Do any of the following interfere with your sexual function[13]? Difficulty maintaining an erection? ☐ Yes ☐ No Decreased lubrication? (for females) ☐ Yes ☐ No Altered (eg. Painful or decreased) sensation? ☐ Yes ☐ No Loss of ejaculation or trickling emission? ☐ Yes ☐ No Autonomic dysreflexia (mainly during ejaculation)? ☐ Yes ☐ No Practical difficulty with positioning or incontinence? ☐ Yes ☐ No Sad or anxious mood ☐ Yes ☐ No ☐ Other _____ Please provide details _____ _____	
12.3 If male, do you achieve an erection by: Reflex erection without medication? ☐ Yes ☐ No Psychogenic erection (in absence of reflex)? ☐ Yes ☐ No Oral medication (eg. Viagra, Levitra or Cialis)? ☐ Yes ☐ No Vacuum device with penile ring? ☐ Yes ☐ No Intracavernosal injection (eg. Cavaject, Papaverine)? ☐ Yes ☐ No ☐ Other _____ Please provide details _____ _____	
12.4 If female, do you use a contraceptive/method? ☐ Yes ☐ No Please provide details _____ _____	
12.5 Are you planning to have children? ☐ Yes ☐ No Have either of you been unsuccessful in having children in the past? ☐ Yes ☐ No Have you or your partner attended a fertility clinic or had an assistive procedure such as electro/vibroejeculation performed previously? ☐ Yes ☐ No Please provide details_____	If person would like to explore this issue further, refer to: ☐ Nearest spinal unit for electro/vibroejaculation ☐ Nearest fertility clinic

[13] Consider possible impact of taking medications that may impair erection, lubrication or ejaculation (eg. anticholinergics, tricyclic antidepressants, antispasmodics). Consider possible psychological concerns (eg. depression, drug & alcohol misuse).

GP MANAGEMENT PLAN		
Issue	**Management plan**	**Outcome**