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

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