Welcome to

Institute of Sports and Spines

Ex Phys New Patient Information Form

Title:_____ Name:_____ Middle Initial/s:____ Surname:_____

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B._____ **Phone:** Home:_____ Work:_____ Mob:_____

*If you are a **current patient** of Institute of Sports and Spines, please skip to **'Reason for Visit'** **section below.***

E-mail address: _____

Private Health Fund: _____ Memb No. _____ No. on Card ____

Medical Practitioner's (GP) Name: _____ Phone: _____

Next of Kin/Emergency Contact:_____ Relationship: _____ Ph: _____

Name of person who referred you to us or how did you hear about us?_____

What is your occupation or major daily activity? _____

Hobbies / Sports / Specific Health interests: _____

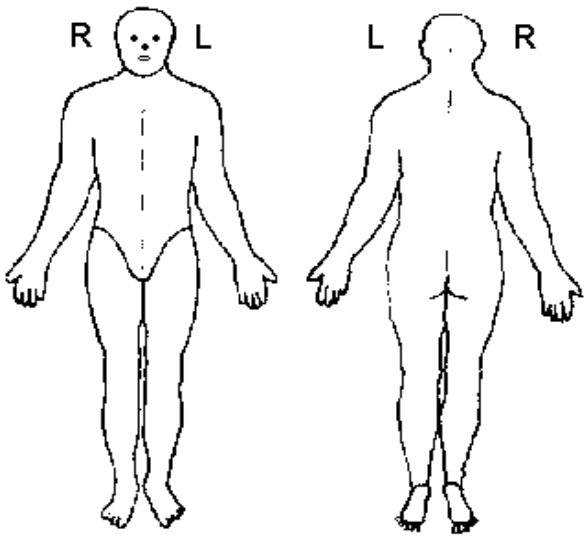
Do you exercise regularly? If so please give details: _____

I would like to receive marketing emails from Institute of Sports and Spines □ Yes □ No

REASON FOR VISIT: _____

Headaches □ Yes □ No Dizziness □ Yes □ No

Please indicate the approximate areas on the diagrams:



Pain - XXXX Pins & Needles - \\\\\\\\\\

Numbness - 000000

Please indicate the level of pain you are suffering.

0_____**10**

How would you describe the pain/problem?

_____

_____

When and how did the problem start? _____

Does it re-occur? □ Yes □ No When and how often?_____

Is the pain worse: □ Morning □ Evening □ During the night Does the pain wake you at night? □ Yes □ No

Does anything aggravate the pain? □ Lying □ Standing □ Sitting □ Movement □ Other _____

Does anything relieve the condition? □ Yes □ No If yes please explain_____

Have you taken any form of pain killer prior to this treatment? _____

What treatment have you had for this condition? _____

What goals do you hope to achieve with treatment? _____

Are you good at maintaining exercises and routines or do you need support? _____

What activities cause you pain? What do you avoid because of the potential for pain or restriction? What would be good benchmarks to use to assess progress?_____

Please fill in page 2-

How many cigarettes per day do you smoke? _____ How many previously and when did you quit? _____
Recent change in? □ Weight □ Vision □ Hearing □ Taste □ Smell Please List: _____

Have you had or do you have existing ailments (If so please give details):-
□ Fractures/ Dislocations _____
□ Major Accident's _____
□ Medical Tests / Blood tests _____
□Surgery_____
□ X-rays _____
□ Medication _____
□ Illness / Infection / fever_____
□ Smoking / Drinking_____
□ Recent GP visit _____
□ Other _____
Have you previously, or do you currently experience any of the following conditions?

□ Are you pregnant	□ Allergies	□ Stroke / DVT	□ Blood/Heart Disorders
□ Migraines	□ Cancer	□ Epilepsy	□ Auto-Immune Disorder
□ Bowel/Bladder	□ Digestive	□ Sexual Dysfunction	□ Thyroid Disorders
□ Stress	□ Anxiety	□ Emotional Disorders	□ Insomnia

Please give details:_____
Do you have a family history of □ Stroke □ Heart/ Blood disorders □ Cancer / Malignancy □ Diabetes □ Other Please List
_____

Exercise Physiology Consent To Treatment – Patient Information

Exercise Physiology services from an Accredited Exercise Physiologist are recognised as being an effective and safe method of care for many conditions. However you must recognise that there are risks with all health care procedures which you should be informed about. Please read carefully
I acknowledge that I will discuss with the Exercise Physiologist the rare risks associated with my proposed care which include, although not limited to muscle and joint soreness, sprains, strains, nausea, dizziness, fractures, disc injuries, strokes, heart attack, hypoglycaemic episodes and an exacerbation and or aggravation of my underlying conditions.
I have the opportunity to discuss the proposed care with the accredited Exercise Physiologist. I also acknowledge that I have the opportunity to ask questions about the nature, extent and purpose of the proposed care and I will be given sufficient time to make a decision giving consent for care.
I acknowledge that I am aware of and understand potential risks and that results are not guaranteed.
I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
I also give consent for my General Practitioner and/or Allied Health Professional to release relevant medical information to the accredited Exercise Physiologist as part of their proposed care plan.
I hereby acknowledge my consent to the performance of the proposed care by the Exercise Physiologist. I understand that I can withdraw consent at any time. I understand that I have given my consent voluntarily without duress or inducements being directed at me.
I give my consent to treatment, which may include exercises, performance testing, shockwave therapy, taping, stretching and home advice. The information I have provided is correct and complete. In signing this document I agree to indemnify the Provider of this service and its employees, agents and representatives from claims made against them in the event that I react to the treatment provided.
We value your time and appreciate helping you with your Health care needs. Your appointment is important. As missed appointments may inconvenience other patients, Failure to attend a scheduled appointment or cancellation within 24 hrs of an appointment will result in a charge of a normal consultation fee. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

Print Full Name:_____ **Sign Here**(or Legal Guardian): _____
Date: / / 20
In our digital form, Entering your name in the box above and returning the forms to us acknowledges that you have read the form and consent to assessment and treatment.