# Welcome to

Institute of Sports and Spines

## Ex & Sports Science 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?**_____
**Referred Internally by:** _____
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

Have you had any previous injuries? _____

Do you have any current injuries? _____

**Highlight or circle YES or NO**

Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?
YES/NO
Do you experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?
YES/NO
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?
YES/NO
Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?
YES/NO
If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?
YES/NO
Do you have any other conditions that may require special consideration for you to exercise?
YES/NO

**REASON FOR VISIT**: _____

_____

What are your exercise goals? _____

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

Do any 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 & Sport Science Consent To Treatment – Patient Information**

Exercise and Sport Science services from an Accredited Exercise Scientist are recognised by the Australian Government as an effective way to receive training. However you must recognise that there are risks with all training procedures which you should be informed about. Please read carefully
I acknowledge that I will discuss with the Exercise Scientist 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 Scientist. I also acknowledge that I have the opportunity to ask questions about the nature, extent and purpose of the proposed training and 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 Exercise Professional to release relevant medical information to the accredited Exercise Scientist as part of their proposed exercise plan.
I hereby acknowledge my consent to the performance of the proposed care by the Exercise Scientist. 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 care, 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.