CLINICAL EXERCISE PHYSIOLOGY

Date: _____/_____/_____

Title: _____ First Name: _____ Surname: _____

Date Of Birth: ___/____/_____ Gender_____ Contact Number: _____

Email: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Occupation:_____

Emegenct Contact: _____ Phone: _____

How did you find out about us? _____

Were you referred to the clinic? N/ Y Referred by: _____

Are you a DVA/ WorkCover/ Medicare CDM/EPC patient?

Medicare Number:_____

Exercise History?_____

Why have you decided to commence exercise physiology services?_____

Does your occupation involve any repetitive movements, or prolonged postures?_____

_____

Associated Osteopathy/Massage treatment (at Move)_____

Are you pregnant: N/ Y/ N/A How many weeks? _____

What aspects of your health would you like to focus on?: -
Core Stability Flexibility Posture Toning Strength Stress management Relaxation

MEDICAL SCREENING

Please list dates and brief details for **illnesses/ hospitalisations/ surgeries/ fractures**

-_____-_____

-_____-_____

Are you taking any medications? Y/N - please list ***Name of medication & reason for taking this medication***

What other sports and hobbies are you involved in?_____

Are you currently experiencing any of the following (please circle)

Lower back pain Pelvic pain any other spinal conditions heart conditions Epilepsy
High or low blood pressure any orthopedic condtions Continence concerns

Have you suffered from any musculoskeletal or serious illnesses in the last 12 months? (if yes provide details)

_____

_____

Current exercise level, frequency duration and intensity?

_____

		YES	NO
1	Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you do physical activity?		
3	In the past month, have you had chest pain while you were not doing physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by physical activity?		
6	Is your doctor currently prescribing drugs for your blood pressure or heart condition?		
7	Are you taking any medication? If yes please give details:		
8	Are you pregnant or recently had a baby?		
9	Have you had any recent injuries or operations? If yes please give details:		
10	Do you know of any other reason why you should not do physical activity?		

Informed Consent to Clinical Exercise Physiology

Private and Confidential

I declare that I have read the Medical Questionnaire and have completed it to the best of my knowledge. I understand that the exercise program will begin at a low level and will be advanced in stages depending on my fitness level. I understand and agree that the therapist/instructor or I can stop the exercise session at any time if I am experiencing any symptoms of fatigue or discomfort or at risk of injury. I understand that there is a risk associated with undertaking any exercise program. I understand (a) whilst every care will be taken it is impossible to predict the body's exact response to exercise and (b) every effort will be made to minimise these risks by evaluation of preliminary information relating to the questionnaire and by observation fitness and technique during exercise. For one to one sessions: I understand that the exercise program will be specifically designed as a personal training plan and will take into account details about me given in my questionnaire and on initial assessment. I understand that this program of exercise should only be undertaken when I have been given specific instructions to exercise on my own. For class sessions: I understand that the exercise program is designed for a general group and not specifically designed as a personal exercise plan. Therefore I understand that the program of exercises should only be undertaken in a supervised exercise class. Further I understand and agree that if I perform any of the exercises outside the class then I do so at my own risk. I agree that Move Osteopathy Instructors, shall not be liable for injuries I suffer in respect of: 1. Exercises I perform outside of a supervised exercise session. 2. Exercises performed other than in accordance with the direction and instructions of the instructor. 3. Undertaking exercises while suffering from an injury or ailment of which I have not informed Move Osteopathy Exercise Physiology services or the instructor. 4. Mishap or injury inflicted by other participants of the exercise group. 5. Any injury sustained while on the premises resulting from personal inattentiveness.

Name: _____
Patient / Parent / Guardian

Signature: _____ Date: _____

CANCELLATION POLICY:

We require 24 hours' notice for all cancellations. If you are unable to make your appointment, please phone us to reschedule your appointment 24 hours in advance if possible. Special considerations will be taken into account for dire circumstances. An appointment reschedule for a different time on the same day will not incur a fee.

I understand that should I cancel within the 24 hr period a cancellation fee may apply.

Name: _____
Patient / Parent / Guardian

Signature: _____ Date: _____
Patient / Parent / Guardian

Please note: *Persons under the age of 18 should have a parent or guardian sign this consent form*