EXERCISE PHYSIOLOGY
NEW CLIENT
REGISTRATION FORM

Date: _____

Title: [Mr/Mrs/Miss/Ms] ☐☐☐☐ ☐ Male ☐ Female ☐ Other

Surname:

First Name:

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Street Address:

Suburb: Post Code:

Telephone: Home Work:

Mobile:

Please provide your email address so we can keep in touch with you.

Email:

Your Dr's Name:

Doctor's Address:

Do you give permission for us to send a letter to your Doctor confirming that you have commenced Treatment?

Yes / No

1. **How did you find out about this practice?**

☐ Advert / Poster ☐ Brochure/ Flyer ☐ Yellow Pages ☐ Yellow Pages Online

☐ Directory Assist ☐ Yellow Pages ☐ Our Website ☐ From My Doctor_____

☐ Friend Referral (name)_____

2. **Private Clients: Do you have Private Health Insurance? ☐ No ☐ Yes** (name)_____

3. **Do you have: ☐ Pensioner Card ☐ Student Card ☐ Health Care Card**

4. **Will your treatment be covered by Veterans Affairs: ☐ No ☐ Yes, Card Number**_____

5. **Do you have a Medicare EPC (Enhanced Primary Care) plan from your doctor? Yes / No**

6. **Are you claiming through Worker's Compensation, MVA or Insurance Commission?**
☐ No ☐ Yes [please complete WC/MVA form]

CONFIDENTIAL PATIENT CASE HISTORY

1. **What is the reason for seeking our services today?**_____

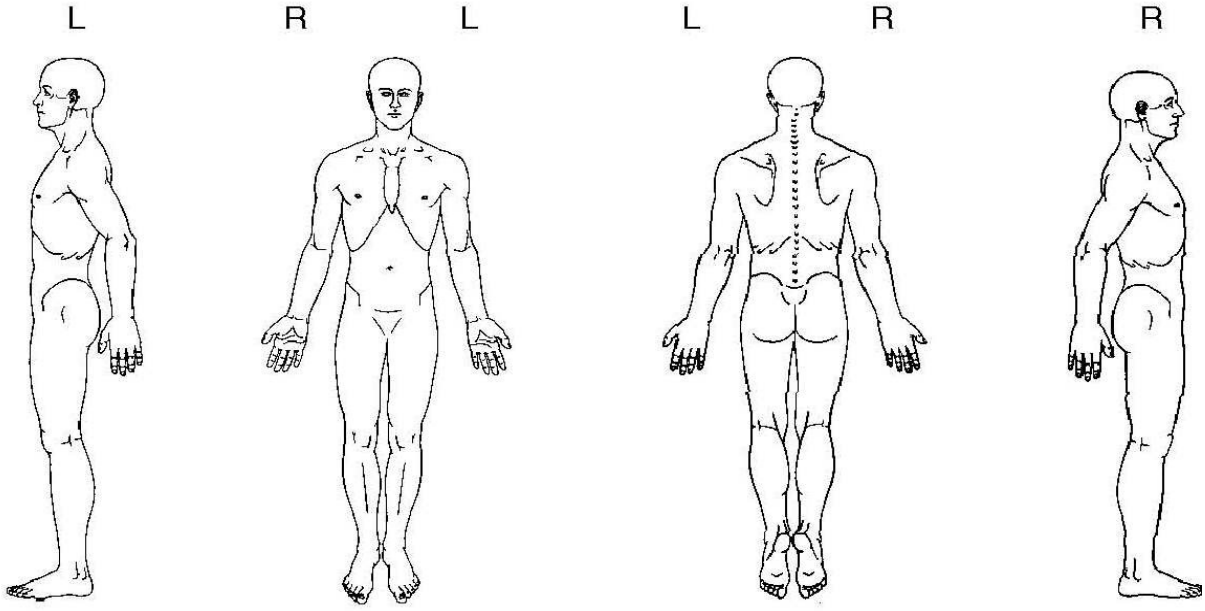
_____

2. **What do you hope to achieve specifically from treatment? (Include goals and deadlines)**

_____

_____

3. Draw on the sketch below the area where you feel your problem to be.



4. How long have you had this problem?

_____

5. Have you had this or a similar problem in the past?

_____

6. If you are experiencing pain, please tick the words that best describe your pain:

☐ Constant or ☐ Comes & goes ☐ Sharp or ☐ Dull Achy

☐ Intensity varies ☐ Intensity doesn't vary ☐ Shooting ☐ Radiates ☐ Travels

7. Do you get?

☐ Pins and needles ☐ Tingling ☐ Numbness ☐ Weakness

8. Since the problem started, is it:

☐ About the same ☐ Getting better ☐ Getting worse

9. What makes your pain worse?

☐ Sitting ☐ Standing up from a chair ☐ Walking

☐ Other_____

10. Does your pain interfere with: ☐Sleep ☐ Hobbies ☐ Leisure ☐ Work

11. What type of work do you do?

_____

12. Have you had any x-rays, ultrasounds, MRI's or CT's relating to this issue? Yes / No

If yes, what and where? _____

13. List any medications you are taking _____

_____

_____

14. Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? Yes / No

15. Are you pregnant? Yes / No / NA If Yes, how many weeks? _____

16. Do you have or have you ever had?: (please tick)

☐ High blood pressure	☐ Cancer	☐ Spinal fracture
☐ Heart attack	☐ Osteoporosis	☐ Spinal surgery
☐ Heart problems	☐ Rheumatoid arthritis	☐ Dislocations
☐ Strokes	☐ Ankylosing spondylitis	☐ Ligament injuries
☐ Diabetes	☐ Psoriatic arthritis	☐ Cartilage injuries
☐ A pacemaker	☐ Reiter's arthritis	☐ Osteoarthritis
☐ An aneurysm	☐ Spinal trauma	☐ Dizziness

17. Have you seen another exercise physiologist before? Yes / No

18. Other health professionals seen for this problem (please list):

Medical doctor _____

Specialist doctor _____

Chiropractoror_____

Physiotherapist _____

Other _____

19. Was there anything you were not happy about with your prior treatment?

_____

20. What aspect were you happy with?

_____

ADULT PRE-EXERCISE SCREENING SYSTEM (APSS)

1. **Has your medical practitioner ever told you that you have a heart condition or have you ever suffered from a stroke** **Yes / No**
2. **Do you ever experience unexplained pain or discomfort in your chest at rest or during physical activity/exercise?** **Yes / No**
3. **Do you ever feel faint, dizzy or lose balance during physical activity/exercise?** **Yes / No**
4. **Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?** **Yes / No**
5. **If you have diabetes (type 1 or 2) have you had trouble controlling your bloor suagar (glucose) in the last 3 months?** **Yes / No**
6. **Do you have any other conditions that may require special consideration for you to exercise?** **Yes / No**
7. **Describe your current physical activity/exercise levels in a typical week by starting the frequency and duration at the different intensities. (intensity guidelines are on the next page)**

Intensity	Light	Moderate	Vigorous	
Frequency (Sessions/week))	_____	_____	_____	Weighted Physical Activity
Duration (total minutes/week))	_____	_____	_____	TOTAL _____ minutes/week

Exercise Intensity Guidelines

INTENSITY CATEGORY	HEART RATE MEASURES	PERCEIVED EXERTION MEASURES	DESCRIPTIVE MEASURES
LIGHT	40 to <55% HRmax*	VERY LIGHT TO LIGHT RPE# 1-2	• An aerobic activity that does not cause a noticeable change in breathing rate • An intensity that can be sustained for at least 60 minutes
MODERATE	55 to <70% HRmax*	MODERATE TO SOMEWHAT HARD RPE# 3-4	• An aerobic activity that is able to be conducted whilst maintaining a conversation uninterrupted • An intensity that may last between 30 and 60 minutes
VIGOROUS	70 to <90% HRmax*	HARD RPE# 5-6	• An aerobic activity in which a conversation generally cannot be maintained uninterrupted • An intensity that may last up to 30 minutes
HIGH	≥ 90% HRmax*	VERY HARD RPE# 7	• An aerobic activity in which it is difficult to talk at all • An intensity that generally cannot be sustained for longer than about 10 minutes

* HRmax = estimated heart rate maximum. Calculated by subtracting age in years from 220 (e.g. for a 50 year old person = 220 - 50 = 170 beats per minute).

= Borg's Rating of Perceived Exertion (RPE) scale, category scale 0-10.

Modified from Norton K, L. Norton & D. Sadgrove. (2010). Position statement on physical activity and exercise intensity terminology. J Sci Med Sport 13, 496-502.

Clinic Policy

Our goal is to deliver an exceptionally friendly and prompt, professional service providing you with the best in chiropractic care. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the **greatest benefit** from our services.

PRIVACY POLICY STATEMENT: In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between practitioners within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Mobile Phones: Out of respect for others, please turn off your mobile phone.

Recovery: Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected we would ask that you discuss this with your chiropractor. We want you to get the most from your care at our clinic.

Excellence in Chiropractic: In order to continue to provide the best, most up to date chiropractic care available we travel periodically to conferences and seminars. To keep your progress on schedule we will attempt to book your appointments around those times or else provide another highly qualified chiropractor to continue your care.

Fees and Your Account: Fees for private patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workers Compensation, Motor Vehicle and DVA patient accounts will be sent directly to the appropriate body where possible. The account financial settlement ultimately still remains the responsibility of the patient.

Referrals: The greatest compliment we can receive is the referral of a friend or family member. The referral of your family and friends is much appreciated as it will both sets them on the road to recovery and wellbeing and plays a vital role in the success of our business. Please let us know the name of your referrer so we may thank them.

Appointment Scheduling: Your chiropractor will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

Missed Appointments: Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given for a cancellation, a cancellation fee may be charged. Consideration will be given for unavoidable circumstances. All missed appointments must be made up later in the same day or within 24 hours to avoid a cancellation fee. This fee is not covered by compensable bodies and must be paid by the patient. People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise we will not be able to help you reach your goals.

Exercise Physiologist Informed Consent

The purpose of this form is to let you know what your rights are and how we address the issue of a collaborative decision making and informed consent between e ercise physiologist and client. Exercise physiologists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds. Once you have given consent, you may withdraw that consent at any time.

Please read and sign the following:

Questions of a personal nature

Your exercise physiologist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the exercise physiologist can provide effective exercise. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the physiotherapist know and they will cease.

Physical contact

During the examination, assessment and e ercise it may be necessary for your exercise physiologist to make physical contact. Your exercise physiologist will ask your permission before making physical contact with you in any way. Wherever possible, contact will be made using a towel or other forms of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

Risk related to treatment

As with all forms of treatment, there are risks and benefits. The exercise physiologist will discuss any foreseeable risks with you prior to commencing exercise. In some cases, the exercise physiologist may ask you to read information related to a particular treatment and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw your consent at any time even if you have previously signed a consent form.

Children and minors

Consent from a custodial parent or guardian is required to treat a minor.

Substituted Consent

Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorized to provide such consent. Evidence of legal authorization is required in such circumstances.

You need to let us know

The risk related to some treatments can increase if the physiotherapist is not aware of certain facts. Please inform the exercise physiologist if you have

- A pacemaker or heart condition
- Suffered from blood clots, thrombosis or stroke
- Suffer from diabetes
- Are currently taking medication

I (the client) acknowledge that I have read and understood the above statements relating to consent for treatment. I offer my consent to receive treatment within the practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Print Patient Name: _____
(Guardian name if patient under 18 years)

Patient Signature: _____
(Guardian signature if patient under 18 years)

Practitioner's Name and signature: _____ **Date**: _____