Exercise Physiology Client Registration Sheet

IMPORTANT PRIVACY NOTICE Information collected by us about you will be stored according to the requirements of Federal Privacy legislation. It will only be passed on where appropriate to the care of the medical problem about which you consulted us (e.g. exercise physiologists to local doctor), or where legally required. If you require more information, ask a staff member to see a copy of our Privacy Policy.

Mr Mrs Miss Ms Dr (Please Circle)

SURNAME_____ GIVEN NAMES_____

ADDRESS_____ POSTCODE_____

DATE OF BIRTH_____/_____/_____ AGE_____ EMAIL ADDRESS_____

TELEPHONE (H) ( )_____ (W) ( )_____ (Mob)_____

PATIENTS OCCUPATION_____ HEALTH FUND_____

EMERGENCY CONTACT_____ TELEPHONE ( ) _____

REFERRAL SOURCE (Please tick appropriate box)

☐ DOCTOR Name_____ Address_____ Referral Date___/___/___

☐ PHYSIOTHERAPIST Name_____ Address_____

☐ COACH Name_____ Sport_____

☐ FRIEND ☐ FAMILY ☐ WEBSITE/INTERNET ☐ YELLOW PAGES

☐ OTHER (Please Specify)_____

COMPLETE ONLY IF WORKERS COMPENSATION OR THIRD PARTY CLAIM

NAME OF EMPLOYER_____ TELEPHONE ( ) _____

ADDRESS OF EMPLOYER_____ POSTCODE _____

NAME OF INSURANCE COMPANY _____TELEPHONE ( )_____

ADDRESS OF INSURANCE COMPANY_____ POSTCODE _____

CASE MANAGER_____ CLAIM NUMBER_____ DATE OF INJURY _____

DOCTOR DETAILS Name_____ Address_____

Telephone ( ) _____ Fax( )_____Referral Date___/___/___

REHAB. COORDINATOR Name_____ Company_____ Telephone ( ) _____

COMPLETE ONLY IF MEDICARE/EPC CLIENT

DOCTOR Name _____ Practice _____

Fax ( ) _____ Telephone ( ) _____ Address _____

REASON FOR REFERRAL _____

_____

PLEASE TICK ☐ Individual Consultation ☐ Group Diabetes

COMPLETE ONLY IF PRIVATE CLIENT

REASON FOR CONSULTATION _____

_____

CURRENT ACTIVITY LEVEL (Please tick one)

☐ Active ☐ Moderately Active ☐ Sedentary

ALL PATIENTS PLEASE COMPLETE

The above knowledge is correct to the best of my knowledge. I have read the privacy notice above. I understand that I will be personally responsible for my accounts if any compensation claim is not accepted and/or not paid by an insurance company.

I agree for my details to be used anonymously for research purposes - Yes / No

I agree to be contacted through any of the means listed above - Yes / No

PATIENT SIGNATURE_____ DATE _____/_____/_____

ADULT PRE-EXERCISE SCREENING TOOL

Stage 1 (Compulsory)

AIM: to identify those individuals with a known disease, or signs or symptoms of disease, who may be at a higher risk of an adverse event during physical activity/exercise. This stage is self administered and self evaluated.

1.	Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke?	Yes	No
2.	Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?	Yes	No
3.	Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	Yes	No
4.	Have you ever had an asthma attack requiring immediate medical attention at any time over the last 12 months?	Yes	No
5.	If you have diabetes (type I or type II) have you had trouble controlling your blood glucose in the last 3 months?	Yes	No
6.	Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?	Yes	No
7.	Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise?	Yes	No

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I believe that to the best of my knowledge, all of the information I have supplied within this tool is correct.

Signature_____ Date_____/_____/_____

Office Use Only

Absolute contraindications:	**Relative contraindications:**
-Unstable angina	-Resting heart rate >125 beats / min after 10 minutes rest
-Acute Myocardial infarction within 2 days	-Systolic blood pressure >200 mmHg ± diastolic blood pressure >110
-Uncontrolled cardiac arrhythmias causing symptoms or hemodynamic compromise	-Left main coronary stenosis
-Resting pulse oximetry (SpO2)% <88% on room air or while breathing the prescribed level of supplemental oxygen	-Moderate stenotic valvular heart disease
-Acute endocarditis, myocarditis, pericarditis	-Electrolyte abnormalities
-Grade IV Heart Failure	-Atrial fibrillation with uncontrolled ventricular rate
-Acute pulmonary embolus or pulmonary infarction	-Hypertrophic cardiomyopathy
-Physical disability preventing safe and adequate test performance	-Mental impairment leading to inability to cooperate
	-High degeree atrioventricular block