

First name Last name

Medicare No DVA File No

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Age

Occupation Date of Birth

Address

Email Address

Mobile No Home No

Emergency Contact Person

Contact No Relationship

How did you hear about us?

# LIFESTYLE

Describe your current weekly physical activity/exercise routine Frequency (times per week)

Intensity **LIGHT/ MODERATE / VIGOROUS**

Time

(minutes per session)

Type of activity/exercise

Do you smoke cigarettes? **YES/NO**

Do you drink alcohol on a daily basis? **YES/NO** If yes, many standard drinks per day?

# MUSCULOSKELETAL

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 (e.g. Osteoarthritis, Multiple Sclerosis, Scoliosis)? **YES/NO**

# MEDICAL HISTORY

Has your doctor ever told you, you have a heart condition or have you every suffered from a stroke? **YES/NO**

Do you ever experience unexplained pains in your chest at rest or during physical activity?

**YES/NO**

Do you ever feel faint or have spells of dizziness during physical activity/ exercise that cause you to loose balance? **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 glucose in the last 3 months? **YES/NO**

Have you been told that you have high blood pressure? **YES/NO**

Have you been told you have high cholesterol? **YES/NO**

Have you been told that you have high blood sugar? **YES/NO**

Do you have any other medical conditions that may make it dangerous for you to participate in physical activity/exercise?

Are you currently taking prescribed medication for any medical conditions?

Have you spent time in hospital (including day admission) for any medical condition/illness/injury during the last 12 months? **YES/NO** Please explain:

Are you pregnant or have given birth within the last 12 months? **YES/NO**

# Why did you come to the session today and what do you want to leave with?

# Do you know why your doctor has referred you to see an Exercise Physiologist?

# What have you been trying already to manage the pain/condition?

# Think about what you would like to achieve in 3 months. Now what do you know about how you can achieve this goal?

# What are your accepted conditions as stated on your DVA card? (if applicable)

# DISCLAIMER

We do not accept responsibility for lost, stolen or damaged valuables, cash or personal items.

I give consent for NAH to record and store notes, medical information, and other pertinent information related to services received at NAH as required by ESSA, DVA, Medicare or any other relevant body. NAH’s privacy policy complies with all Commonwealth, State and local privacy laws. This privacy policy can be viewed on request.

Liability release, acknowledgment and waiver

The undersigned, understands, acknowledges and agrees that:

1. I am aware that the facilities and services offered Northside Allied Health involve risk, included but not limited to, risk of bodily injury;
2. I have provided above all the relevant information regarding my medical history and current health status;
3. I am making use of the fitness facilities and services of Northside Allied Health of my own free will;
4. I assume all risks associated therewith.

On behalf of myself and my heirs I hereby release and discharge the entity that operates and Northside Allied Health (the ‘owner’) and all of the affiliates, subsidiaries, employees, directors, officers, agents, landlords, representatives, successors and assigns of the Owner from any and all claims or causes of action arising out of or relating to my use of the facilities and services of that entity, including but not limited to, those resulting from bodily injury or theft, or loss of, or damage to, property of mine unless due to the gross negligence or willful misconduct of the Owner or its employees

Signature:

Date:

veteransexercise123@gmail.com Ph: 0412 740 322 Fax: 5302 0730

veteransexercise.com.au

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**CANCELLATION POLICY**

This cancellation policy is in place to charge you if you do not give 24 hours notice of your intention to cancel. There will be a $20 cancellation fee charged. We will issue you with an invoice for payment.