# EXERCISE PHYSIOLOGY INITIAL CONSULTATION

NEW PATIENT FORM INFORMATION

Name:
Date of Birth:
Address:
Phone:
Email:
Emergency contact (name, relationship and number):
Referring physician (if applicable):

| Injuries/surgeries (including joint replacements) | Medications & dosages | Allergies |
|---|---|---|
| | | |

| Past medical history | Current medical conditions |
|---|---|
| | |

Family history health and conditions _____
(relevant to exercise) _____
_____
_____
_____

## EXERCISE HISTORY

| Current exercise routine | Exercise goals | Previous experience exercise |
|---|---|---|
| | | |

**SMOKING HISTORY/USE:** _____

**ALCOHOL HISTORY/USE:** _____

## OTHER LIFESTYLE FACTORS

| | |
|---|---|
| **Sleep Patterns** | |
| **Dietary Habits:** | |
| **Occupation:** | |

## CARDIOVASCULAR ASSESSMENT

| | |
|---|---|
| **Blood Pressure:** | **/ mmHg** |
| **Resting HR:** | **bpm (APHR % = BPM)** |
| **Sp02:** | **%** |

## BODY ASSESSMENT

| | |
|---|---|
| **Weight** | |
| **Height:** | |
| **BMI:** | |
| **Hip to Waist:** | **H: W: Ratio:** |

## STRENGTH / ENDURANCE ASSESSMENT

| | |
|---|---|
| **Grip Strength:** | **(L) kg & (R) kg** |
| **Step ups:** | |
| **Push ups:** | |
| **Sit-to-stands:** | |

## BALANCE TESTS

**SLS:**
**TUG3m:**

# Informed Consent

Exercise Physiology (EP) involves the prescription of several stretches, exercises and movements. The EP's administering treatment are all appropriately qualified and covered by the appropriate insurance. Your informed consent is required for all treatments at our practice. Please read the following and tick where agreeable:

| | | | |
|---|---|---|---|
| The techniques used during treatment will always be discussed with you, outlining the possible benefits and risks, and whether the treatment is conventional or experimental. | | All forms of treatment carry some risks. These will be outlined to you, and you have the sole discretion of continuing or discontinuing treatment. | |
| You have the right to withdraw your consent at any time, and treatment will cease. | | Your medical information may be disclosed to other health professionals that are caring for you (GP, Physio, Specialist, Podiatrist, Chiro, Insurance company, Rehabilitation consultant, Employer (*only if WorkCover)* | |
| If you become uncomfortable at any time, or wish to discuss your treatment, you have the right to do so. | | I give consent for treatment and agree to the risks and benefits outlined. This consent remains valid until such time as I withdraw it. I have read and fully understood the clinic Privacy Policy and Consent Policy | |

## Assessment & Privacy:

For assessment purposes (e.g., posture, movement analysis, muscle activation), you may be asked to adjust or remove certain outer garments. This may not be applicable to all patients. It will always be discussed with you beforehand, your comfort and privacy will be always respected, and you may decline on the day without affecting your care.
ACKNOWLEDGMENT: _____

We may use a contracted virtual administrative assistant, which may be based offshore, to assist with processing patient registration information (e.g., data entry and appointment administration). Any access to personal information is limited to what is necessary, is subject to strict confidentiality requirements, and is managed using secure systems and access controls. We take reasonable steps to protect your personal information and handle it in accordance with applicable privacy laws
ACKNOWLEDGMENT: _____

| **Types of goals** | Practitioner goals | Patient expectations |
|---|---|---|
| Short Term | | |
| Long Term | | |
| Outcomes | | |

| Special Tests / Flexibility Tests *(If applicable)* |
| --- |
| |

| Nutrition concerns (if applicable) | Hydration concerns (if applicable) |
| --- | --- |
| | |

| | |
| --- | --- |
| **Future session appointments and plan** | |

## Client Acknowledgment:

I have reviewed and understood the information provided during this initial consultation. I acknowledge that the exercise program and recommendations are based on the information I have provided about my medical history, goals, and expectations.

**Client Signature:**
Date:

**Exercise Physiologists Signature:**
Date: