CLIENT INFORMATION & CONSENT

Contact Details

Mr / Miss / Ms / Mrs

Surname: _____ Date of Birth: ___ / ____ / _____

First Names: _____

Preferred Name: _____ Home Phone: (__) _____

Residential Address: _____ Work Phone: (__) _____

_____ Mobile Phone: _____

Gender: Male / Female E-mail: _____

Occupation: _____ Employer:_____

Emergency Contact

Name: _____ Phone: _____

Relationship to you: _____ Mobile: _____

General Practitioner

GP Name: _____ Practice: _____

Are you currently seeing any other Medical or Allied Health professionals for treatment? Yes / No

Please specify: _____

Private Health Fund: Yes/No If yes, please specify: _____

DVA number (if appropriate): _____ DVA Gold Card [ ] DVA White Card [ ]

Workers Compensation (if appropriate):

Insurer: _____ Claim No: _____

Case Manager: _____ Contact Ph: _____

Additional management team members:

Name: _____ Phone: _____

Name: _____ Phone: _____

I understand that the above information is kept confidential and have answered all of the above to best of my knowledge

_____ _____

Signature Date

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Written Informed Consent

I, (Please print your FULL NAME) _____ have advised my medical history, injuries and any other relevant information that may influence my exercise program to the best of my ability. I will advise if there are any changes to this information during my treatment period.

Information collected may be used for exercise testing and prescription. This information may be given or provided to any other medical/health professionals or other parties involved with my case / care. I give permission for my Accredited Exercise Physiologist and staff members to speak with relevant parties and professionals in regards to any medical conditions, injuries or other information that may influence my treatment or exercise / fitness program. I understand that some forms of communication (e.g. the internet and facsimiles) can be an insecure means of communication, and I am aware of the risk that the data sent may be accessed and read during and or after transmission.

Medical Release - I understand there are risks, discomforts and unhealthy changes (e.g. dizziness, abnormal heart rhythms and in some circumstances death eg heart attack) associated with exercise and exercise testing. It is my responsibility to promptly inform staff members of any unusual feelings or concerns. I am voluntary participating in this program. I may stop at any given time, if I so desire without consequence.

Information provided by the Accredited Exercise Physiologist is only used as a guideline to establish limitations in my exercise program. I will exercise and participant in all consultations at my own risk and I, or my estate, will not hold any gymnasium, studio or Accredited Exercise Physiologist accountable for any losses, damages, costs, claims, injury, liability sustained or incurred by my participation in exercise. I acknowledge that I may come in to contact with staff members.

Mums & Bubs - I agree to include my child in Mum's & Bub's classes at our own risk. I understand that it is recommended for children involved to not be 'on the move' (ie not rolling, crawling or walking) as this significantly increases the risk of injury.

Media Release - I grant permission to 360 Health Clinic, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

- ☐ Videos
- ☐ Email Blasts
- ☐ Recruiting Brochures
- ☐ Newsletters
- ☐ Magazines
- ☐ General Publications
- ☐ Website and/or Affiliates

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Package Purchases - I understand that all Packages purchased with 360 Health Clinic are non-refundable and cannot be used to redeem sessions for anyone else.

I agree to the expiry periods outlined below:

- Class Pass - 4 month expiry
- 1:1 Packages - 6 month expiry

Cancellation Policy - I agree to provide AT LEAST 6 hours' notice to cancel or reschedule a booking with 360 Health Clinic. I understand that failure to provide this notice will result in a $25 fee payable by me, or a deduction of one class from my package.

By signing below I agree I have had the opportunity to ask questions and am satisfied with all responses.

Signature: _____ Date: _____/_____/_____

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Pre Exercise Screening Questionnaire

On this questionnaire, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Please ask if you have any questions. Your responses will be treated in a confidential manner.

Medical Screening

1. Has your Doctor ever told you that you have a heart condition of have you suffered a stroke?	YES	NO
2. Do you ever experience unexplained pains in your chest at rest of during physical activity/exercise?	YES	NO
3. Do you ever feel faint or have dizziness during physical activity/exercise causing you to lose balance?	YES	NO
4. A) Do you suffer from asthma? B) Have you had an asthma attack requiring immediate medical attention in the last 12 months?	YES YES	NO NO
5. A) Do you have diabetes (TI or TII)? B) Have you had trouble controlling you blood glucose levels in the last 3 months?	YES YES	NO 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 suffer from Epilepsy or Seizures?	YES	NO
8. Are you pregnant or have you given birth in the past 12 months?	YES	NO
9. Do you have any other medical conditions that may make it dangerous for you to engage in physical activity/exercise?	YES	NO

Physical Activity History

Describe your current physical activity/exercise levels in a typical week:

Intensity	**Light**	**Moderate**	**Vigorous/High**
Frequency (Sessions per week)			
Duration (Total minutes per week)			

Type of exercise: _____

Risk Factors

Do you smoke cigarettes or have you quit smoking in the last 6 months? YES / NO

If yes, how many per day? _____

Do you drink alcoholic beverages on a daily or weekly basis? YES / NO

If yes, how many per day/week? _____

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

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

Have you been told you have high blood glucose? YES / NO

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Do you have any muscle, bone or joint pain?

Neck/Shoulder ❑ Back ❑ Hip ❑ Knee ❑ Foot/Ankle ❑

Please describe:

_____

_____

Medical History (Optional)

When was your last check up with your GP ____/_____/___

Reason for visit: _____

Please list any medications you currently take, including dosage if known

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you spent any time in hospital in the last 12 months, including day admission YES / NO

Family History (Optional)

Have your mother, father, or siblings suffered from (please select all that apply):

- ❑ Heart attack/disease or surgery
- ❑ Stroke
- ❑ Obesity
- ❑ Asthma
- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Leukemia or cancer prior to age 60

Today's Date: ____/____/____ Client's Signature: _____

ACCREDITED EXERCISE PHYSIOLOGIST
360 HEALTH CLINIC, TAMWORTH 02 6762 3639