PRE-ASSESSMENT FORM

Below you will find a detailed consultation form which must be complete prior to your first visit with Body Motion. Please make sure you fill in all required fields and remember to answer honestly, for this will help guide your program/recovery.

PERSONAL INFORMATION

First Name

Last Name

Your Address

City

City

State

Postcode

Your Mobile

Your Home Number

Email Address

Gender

D.O.B

Emergency Contact

MEDICAL HISTORY

Occupation

GP Name and Address

Funding: Private

Health Fund

NDIS

Y ☐ N ☐

Medicare (CDM/GP management plan)

Y ☐ N ☐

DVA

Y ☐ N ☐

How did you hear about us

If Friend or Family are you happy to tell us who so we can thank them?

Please tick YES or NO for the following:

Diabetes

○ Yes ○ No

Asthma, COPD or respiratory conditions

○ Yes ○ No

Epilepsy or Seizures

○ Yes ○ No

Neurological Disorders, Anxiety, Depression

○ Yes ○ No

High Blood Pressure

○ Yes ○ No

Heart Disease

○ Yes ○ No

Do you smoke

○ Yes ○ No

Are you pregnant

○ Yes ○ No

Broken bones, sprains, dislocations

○ Yes ○ No

Arthritis - Osteoarthritis, Rheumatoid, Juvenile

○ Yes ○ No

Recent surgery, or hospitalisation

○ Yes ○ No

Headaches, migraines, concussion

○ Yes ○ No

Chief complaint - What is the reason for booking a consult?:

Medications:

Medical / Surgical History:

Sports / Activities:

CONSENT AND SUBMIT

Consent to Treatment

I am of sound mind to make the informed choice to participate in any ongoing exercise programming conducted by Body Motion. I understand this document in full, and have given an honest and complete account of my history. I consent to assessment, treatment, and the possible use of videography for assessment and treatment purposes while working with Body Motion.

Confidentially

I agree and grant permission for Body Motion to disclose, where reasonably necessary, any required medical and personal information to third parties including: general practitioners, physiotherapists, hospitals, insurance agencies acting on your behalf and other health professionals in the event that reasonable information is required to be able to provide optimal services for your health and physical progression.

Parental / Guardian Consent: (Only for patients under 16)

Full Name

☐ Accept terms