

Welcome to Pilates!

Title: _____ First Name: _____ Surname: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

☎ Mobile: _____ ☎ Work: _____ ☎ Home: _____

Email (used for appointment reminders): _____

Occupation: _____ Employer: _____

Location: _____

Do you have Private Health insurance (e.g. Medibank, HBF etc.)? Y / N Indicate Fund: _____

Your Health Information:

Are you a smoker? _____ if yes, please indicate number of cigarettes per day: _____

GP's Name: _____ GP's Practice Location: _____

Do you give Bodysmart permission to contact your GP if required? Yes No

How did you hear about Bodysmart Health Centre?

Google/Bing Yellow Pages Workplace Expo Flyer - Workplace Health Insurance Website

Newsletter Flyer - Street Gym Member Internet Search Ergonomic Assessment

Doctor (Please specify name and practice location) _____

Friend /Colleague (**Please specify full name**) _____

Other (Please specify) _____

Are there any songs/ artists you would recommend for our clinic playlist? _____

Please indicate if this treatment is:

Private Consultation Workers Compensation Injury

Motor Vehicle Injury Enhanced Primary Care (Medicare)

Department of Veteran Affairs

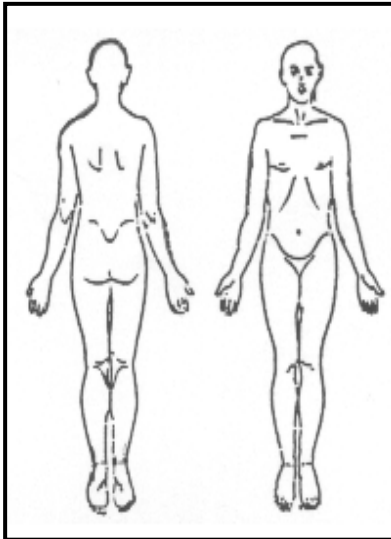
PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING IN THE LAST 6 MONTHS:

<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Leg weak / numbness
<input type="checkbox"/> Pelvic Instability	<input type="checkbox"/> Hand / wrist pain	<input type="checkbox"/> Osteitis Pubis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Total Hip replacement	<input type="checkbox"/> Spinal Stenosis	<input type="checkbox"/> Trochanteric Bursitis	<input type="checkbox"/> Ankle / foot weakness
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Foot / toe numbness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Spondylolisthesis	<input type="checkbox"/> Thoracic Outlet Synd.	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Unexplained Nausea	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Shoulder Impingement	<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Pain that wakes you at night	<input type="checkbox"/> Pelvic floor issues/incontinence		

Please turn the form over and complete page 2

Your Symptoms

Please indicate your main areas of pain by circling the diagram below:



Please list and date any INJURY, ILLNESS or SURGERY (including cosmetic) you are currently (or previously) had:
Please list all medications and/or vitamins/supplements you are currently taking:
Please indicate your two goals you aim to achieve through starting Pilates:
1)
2)

Have you practiced Pilates before? Yes No
 If yes: Matwork Reformer

If yes, at which location: _____ approx. date: _____

Current Exercise Regime (Please describe your current weekly exercise):

Have you experienced any feelings of heaviness in the lower abdomen or incontinence whilst exercising: Yes No

As part of our Pilates program, we offer the opportunity for before and after postural photos. These are secured and only available to be viewed by your therapist. Please indicate if you would like postural photos taken: Yes No

We highly recommend receiving our Pilates monthly newsletter (This depicts availability of current classes and also offers specials and promotions including cash discounts month to month) Opt in Opt out

Would you like to receive a link to our Facebook page? Yes No
 (Giving you occasional special offers and updates)

Have you seen another Physio / Chiro in the last 6 months? Yes No

Have you had any X-Rays / scans in the last 5 years? Yes No

Would you like further information about the following Bodysmart Products / Services?

- Physiotherapy Remedial Massage Chiropractic
- Functional Training Ergonomic Assessments Fitting your child's Backpack
- Ergo Products (Please Circle): Sit-Stand Desks | Chairs | Mice | Keyboards | Backpacks

Cancellation Policy

In the interest of other patients who may miss the opportunity of an appointment they may need, and to ensure appointments run on time, an Appointment and Cancellation Policy applies to all appointments.

***** PLEASE READ APPOINTMENT AND CANCELLATION POLICY INTRODUCED 2011 *****

I have read and I agree to the terms and conditions of Bodysmart's Appointment and Cancellation Policy 2011. I understand that if I fail to attend, or fail to cancel a scheduled appointment with less than 4 hours notice I WILL pay a cancellation fee.

PATIENT'S SIGNATURE: _____ Date: _____