ekso BIONICS

FOR THE HUMAN ENDEAVOR

EKSO BIONICS CUSTOMER INFORMATION FORM

PLEASE FILL OUT THE FOLLOWING COMPLETELY AND ACCURATELY, AND RETURN TO: BRICHARDS@EKSOBIONICS.CO
OR POST TO BELOW ADDRESS.

PATIENT CONTACT

NAME: _____

ADDRESS: _____

_____

POST CODE: _____

COUNTRY: _____

DATE OF BIRTH _____

TELEPHONE HOME: _____

MOBILE: _____

EMAIL ADDRESS: _____

PARENT / GUARDIAN CONTACT INFORMATION

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

POST CODE: _____

COUNTRY: _____

TELEPHONE HOME: _____

MOBILE: _____

EMAIL ADDRESS: _____

MEDICAL PRACTITIONER

NAME: _____

FACILITY ADDRESS: _____

POST CODE: _____

COUNTRY: _____

TELEPHONE/ EXT: _____

EMAIL ADDRESS: _____

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MEDICAL HISTORY

NEUROLOGICAL CONDITION _____

_____

DATE OF INJURY/ DIAGNOSIS: _____

_____

TYPE AND LEVEL OF INJURY / PARALYSIS _____

_____

_____

_____

_____

ANATOMICAL MEASUREMENTS

HEIGHT:_____CM

WEIGHT:_____KG

CURRENT FUNCTION

WHEN DID YOU LAST STAND AND FOR HOW LONG?

		HOW LONG
☐	LAST WEEK	_____
☐	LAST MONTH	_____
☐	LAST YEAR	_____
☐	NOT STANDING	_____

ARE YOU ABLE TO TRANSFER FROM YOUR WHEELCHAIR TO A REGULAR CHAIR INDEPENDENTLY?

☐ YES
☐ NO

ARE YOU ABLE TO GRASP AND RELEASE OBJECTS IN YOUR HANDS?

☐ YES
☐ NO

DO YOU HAVE SITTING BALANCE?

☐ YES
☐ NO

WHAT IS YOU USUAL FORM OF MOBILITY?

☐ MANUAL WHEELCHAIR
☐ POWERED WHEELCHAIR

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DO YOU SUFFER FROM OR HAVE

FRACTURES IN YOUR LEGS:	☐ NO ☐ YES	WHEN_____
LEG LENGTH DISCREPANCY :	☐ NO ☐ YES	
LOW/ UNSTABLE BLOOD PRESSURE:	☐ NO ☐ YES	
DIZZINESS/MOTION SICKNESS:	☐ NO ☐ YES	WHEN/ HOW OFTEN?_____
UNCONTROLLED MOVEMENTS OF YOUR LIMBS:	☐ NO ☐ YES	CLONUS/ SPASMS/SPASTICITY OTHER :_____
UNCONTROLLED AUTONOMIC DYSREFLEXIA:	☐ NO ☐ YES	
SEIZURES:	☐ NO ☐ YES	DATE OF LAST EVENT:_____
UPPER LIMB WEAKNESS/ INJURY:	☐ NO ☐ YES	DATE OF LAST EVENT:_____
HEARING/ VISUAL/ SPEECH DEFICITS:	☐ NO ☐ YES	
MEMORY DEFICITS:	☐ NO ☐ YES	
SKIN CONDITION:	☐ NO ☐ YES	
COLOSTOMY:	☐ NO ☐ YES	PRESSURE AREAS/SORE/ FRAGILITY _____
OSTEOPOROSIS:	☐ NO ☐ YES	
RECENT SURGERY:	☐ NO ☐ YES	

MEDICAL INVESTIGATION AND CURRENT MEDICATION

Are you currently having any medical investigation? ☐ NO ☐ YES

Please give a brief description

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What medication are you taking?

_____
_____
_____
_____
_____

ADDITIONAL INFORMATION AND SIGNATURE

Please describe any additional information that will be of interest for us regarding your medical health or any other information that will assist us in providing the best possible experience.

_____
_____
_____
_____
_____

Customer Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Please print): _____