FOR THE HUMAN ENDEAVOR

# EKSO BIONICS CUSTOMER INFORMATION FORM

PLEASE FILL OUT THE FOLLOWING COMPLETELY AND ACCURATELY, AND RETURN TO: ENQUIRIES@EKSOBIONICS.COM, 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: _____

## CONSULTANT NEUROLOGIST

NAME: _____

FACILITY ADDRESS: _____

POST CODE: _____

COUNTRY: _____

TELEPHONE/ EXT: _____

EMAIL ADDRESS: _____

ekso BIONICS

FOR THE HUMAN ENDEAVOR

## 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

ekso BIONICS

FOR THE HUMAN ENDEAVOR

## 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/ spams/spasticity other :_____ |
| Uncontrolled autonomic dysreflexia: | ☐ No ☐ Yes | Date of last event:_____ |
| Seizures: | ☐ No ☐ Yes | Date of last event:_____ |
| Upper limb weakness/ injury: | ☐ No ☐ Yes | |
| Hearing/ visual/ speech deficits: | ☐ No ☐ Yes | |
| Memory deficits: | ☐ No ☐ Yes | |
| Skin condition: | ☐ No ☐ Yes | Pressure areas/sore/ fragility _____ |
| Colostomy: | ☐ No ☐ Yes | |
| 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

_____

_____

_____

FOR THE HUMAN ENDEAVOR

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): _____

BB Approval: _____

Date: _____