Jack Willow's
HEALTH & WELLNESS CENTRE
Shop 13/107-111 Morayfield Road
Caboolture South QLD 4510
ABN: 60602270600
Ph: 07 5428 2849 Fax: 07 5428 2877
Email: info@jackwillows.com.au

Exercise Physiology Health History Form

Please return this completed form via email or in person before your next appointment, Thank you.

Personal Details

Name:_____DOB:_____Gender:_____
Address:_____Suburb:_____Postcode:_____
Phone (W): _____Phone (M): _____Phone (H): _____
Email: _____
How did you hear about us? _____

Emergency Contact Details

Contact Name: _____Relationship: _____
Phone (W): _____Phone (M): _____Phone (H): _____

Medical & Referral Details

Doctor: _____Clinic: _____
Address: _____Suburb: _____Postcode: _____
Phone (W): _____ Provider Number: _____Ref Date: _____
Number of sessions: _____

Referral type: *(please circle which one)*

Private GPMP DVA T2D Group Education Group Exercise

WorkCover Other: _____

Referral Code: *(please circle which one)*

GPMP 10953	ATSI 81315	DE IC 81110	DE Gp 81115
DVA Surg EP01	DVA Home EP02	DVA Gp EP07	WC IC 300186
WC F/U 300187	WC Gp 300401		

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Health History

Have you had, or do you have, any of the below health conditions? If you answer yes, please give details.

1) Cardiac conditions? E.g. heart or chest pain No Unsure/maybe Yes _____
2) Cholesterol? No Unsure/maybe Yes _____
3) High/Low blood pressure? No Unsure/maybe Yes _____
4) Breathing or respiratory conditions? E.g. Asthma No Unsure/maybe Yes _____
5) Metabolic conditions? E.g. Diabetes or thyroid No Unsure/maybe Yes _____
6) Balance because of dizziness? No Unsure/maybe Yes _____
7) Bone or joint problems? E.g. Osteoporosis or arthritis No Unsure/maybe Yes _____
8) Muscle problems? No Unsure/maybe Yes _____
9) Pain? No Unsure/maybe Yes _____
10) Injuries or bio-mechanical limitations? No Unsure/maybe Yes _____
11) Epilepsy? No Unsure/maybe Yes _____
12) Allergies? No Unsure/maybe Yes _____
13) Psychological? E.g. Anxiety, depression? No Unsure/maybe Yes _____
14) Have you been, are you or could you be pregnant? No Unsure/maybe Yes _____
15) Other E.g. Organs, cancer _____
16) Is there a family history of any of the above conditions? _____
17) Please list any medications, including vitamins, that you are currently taking. _____
_____
_____

If you answered yes to two or more of the above, talk to your medical practitioner prior to commencing exercise for a medical clearance.

Lifestyle History

Please answer the below lifestyle questions. If yes, please give details.

1) Are you involved in any incidental activity? E.g. household chores, walking upstairs (a*ctivities*)
_____
2) Do you participate in any cardiovascular activity? E.g. walking, yard work, group fitness (activities)
_____
_____Days per week _____ Minutes each time _____

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3) Do you participate in resistance training activity? *(activities)* _____
_____
_____Days per week _____ Minutes each time _____
4) Do you participate in flexibility training activity? *(activities)* _____
_____
_____Days per week _____ Minutes each time _____
5) Do you participate in any structured recreational or sporting activities? *(activities)* _____
_____
_____Days per week _____ Minutes each time _____
6) What is your occupation? _____
7) Do you, or have you, smoked? _____Never previous _____Current *(per day)* _____
8) What are your sleep habits like? _____
* Fine * Trouble falling asleep * Trouble staying asleep * Wake up tired

Nutritional History

Please answer the below nutritional questions based on an average day.

1) How many serves of vegetables would you consume?
None <5 5 >5
2) How many serves of fruit would you consume?
None <2 2 >2
3) How many serves of protein would you consume?
None <2 2 >2
4) How many serves of carbohydrates would you consume?
None <4 4-9 >9
5) How many serves of dairy would you consume?
None <2 2 >2
6) How many serves of processed and/or high fat foods would you consume?
None <2 2 >2
7) How many standard alcoholic beverages would you consume?
None <2 2 >2
8) How many serves of caffeine, tea or soft drinks would you consume?
None 1 2 >2
9) How many glasses of water would you consume?
None <8 8 >8

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Goals

1) What activities of your everyday life would you like to be able to perform better?_____
_____

2) What injuries would you like to improve? _____
_____

3) What medical conditions would you like to improve? _____
_____

4) What event of sport would you like to be able to perform better?_____
_____

5) What areas of you r body would you like to improve? _____
_____

6) In six months what would you like to achieve? _____
_____

How confident are you being able to achieve the goals you have written above? (0=not, 10=totally)
_____