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
WC F/U 300187  WC Gp 300401
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 (activities)

2) Do you participate in any cardiovascular activity? E.g. walking, yard work, group fitness (activities)

   Days per week
   Minutes each time
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
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 your 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)