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)

____