KARE | HEALTH CENTRE

Pre-Consultation Questionnaire – Exercise and Diet

Full Name: Mr./Mrs./Ms./Miss_____ DOB: _____ Age:_____

Address: _____

Tel (H): _____(W): _____(M): _____

Treatment Details

Reasons for treatment: _____

Type of Health Fund:

□Private Health Fund □Workers Compensation □Motor Vehicle Accident □Medicare/DVA/EPC

Insurance Company: _____Claim/Membership Number: _____

Personal History

What is your occupation? _____

Marital status: Married Single De facto

How many children do you have? _____

Are you currently pregnant? Y/N

Medical History

Name of your family Doctor:_____

Do you suffer from diabetes? Y/N

Do you have a family history of heart disease (Mum, dad, sister or brother only)? Y/N

Have you ever had any heart related issues? Y/N

Are you suffering from, or have a family history of any of the following?

□ Asthma/Breathing Difficulties	□ High blood pressure	□ High cholesterol
□ Angina/Chest Pain	□ Stroke	□ Cancer
□ Bowel/Bladder Incontinence	□ Gout	□ Dizziness
□ Headache/Migraine	□ Blurred Vision	□ Arthritis

List any other previous major health related issues or surgical procedures

Illness	Date/Year of diagnosis
•	
•	
•	
•	

List any current prescribed medications you are taking

-
-
-

Body Shape

Please circle how you would most like to change your body weight and shape

Decrease weight/size Increase weight /size Tone or build muscle Maintain current weight/size

Current Physical Activity Levels

What is your level of formal exercise per week?

Sedentary	Occasional	Moderately	Active	Very Active
No regular exercise or minimum daily activity	Moderate exercise 1-2 times x 30 min	Active 3-4 times x 30 min	5 x 30 min	>5 x 1 hour vigorous activity

Diet

How often do you eat breakfast?

Every day 4-6 days/week 1-3 days/week Fortnightly or less

How often do you eat restaurant or takeaway meals?

Every day 4-6 days/week 1-3 days/week Fortnightly or less

How many glasses of water do you drink per day?

<2 2-3 glasses 4-5 glasses 6-7 glasses >7

How many serves of fruit do you usually eat per day?

Don't eat fruit regularly <2 2-3 >3

How many serves of vegetables do you usually eat per day?

Don't eat vegetables regularly <2 2-3 >3

Smoking and Alcohol

How many cigarettes do you have per day? _____

How often do you drink alcohol?

More than 5 times/week 2-5 times/week Once/week Monthly or less Never

How many standard drinks do you have on a typical night?

None 1-2 3-4 5-6 7 or more

How often do you have 6 or more drinks (male) or 4 or more drinks (females)?

Never Less than monthly Monthly Weekly Daily

Perceived Stress Levels

On a Scale of 1 to 10 rate your current stress levels

1 2 3 4 5 6 7 8 9 10

What are your main source of stress? Work life Home Life Other

Do you actively use any stress management strategies into your lifestyle? (E.g. meditation, exercise, counselling sessions?) Y/N

Consent for Treatment

Signature: _____Date: _____