Health & Lifestyle
Questionnaire

ABSOLUTE BALANCE
Exercise Physiology Group

Privacy and Confidentiality

Name | Email
Company/Dept | Phone
DOB | Gender M F

Please complete this questionnaire and email OR bring with you to your health appraisal appointment. This information will be use by the allied health professional to identify key health risk areas and provide you with a personalised health snap-shot. All information is kept strictly confidential in accordance with the Federal Privacy Act (1988) and the Privacy Amendment (Private Sector) Act (2000)

Have you or a family member had any form of heart disease, a heart condition or suffered a stroke?
(Heart Murmur, Heart Attack, Heart Palpitations, Coronary Thrombosis) Y N

Details:

Do you suffer from any chronic disease?
(Diabetes, Hypertension, Obesity, Asthma, Cancer, Depression, Arthritis, Chronic Obstructive Pulmonary Disease)
Y N

Details:

Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?
Y N

Details:

Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to loose balance?
Y N

Details:

Have you had any previous surgeries we should be aware of? Y N

Details:

Have you had any serious illnesses or muscle, bone or joint problems we should be aware of?
Y N

Details:

Do you have any serious injuries at present? Y N

Details:

Are you currently taking any prescriptive medicinal aids? Y N

Details:

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Smoking

- Nil/Non Smoker
- Previous Smoker
- Smoke 2-10 per day
- Smoke 10+ per day

Diet

Water (glasses per day)	Fruit (serves per day)	Vegetables (serves per day)
2-4	0	0-2
4-6	1	3-4
6-8	2+	5+
8+		

Alcohol

Average Alcohol Consumption (standard drinks)	Alcohol Free Days/Week
Nil/Non Drinker	0
1-2 drinks per day	1-2
3-4 drinks per day	3-4
5-6 drinks per day	5-7
6+ drinks per day	

Stress

Please rate your perceived stress level in the last month (1=low, 10=high)

1 2 3 4 5 6 7 8 9 10

Please rate your work/life balance (1=poor, 10=excellent)

1 2 3 4 5 6 7 8 9 10

Sleep

How many hours of sleep do you get per night (average)

3 or less 4-5 6-8 9+

Physical Activity Levels

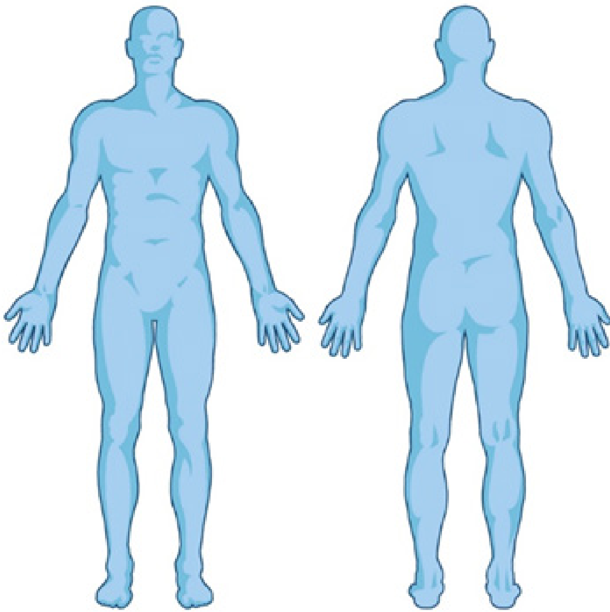
On average, rate your physical activity level;

- Sedentary (<1hr per week)
- Occasional (1-2hrs per week)
- Moderately Active (2.5- 4hrs per week)
- Very Active (5+ hrs per week)

What forms of exercise/sport/leisure activities do these include?

Pre-existing Injury Details

Please mark on the body charts below where you feel pain.



What movements, activities, or body positions cause pain?

Details:

How long has the pain troubled you?

Details:

Does it impact the way you exercise? Y N

Details:

Do you have a current or previous workers compensation claim for the above mentioned injuries?

Y N

Details:

Freedom of Consent

Your permission to perform these assessments is voluntary. You are free to deny consent if you so desire.
By signing this declaration I acknowledge that the information above is completely honest and true to the best of my knowledge and I consent to participate in the assessment.

NAME:

SIGNATURE:

DATE: