CLIENT EXERCISE SAFETY QUESTIONNAIRE

Client Name: ____ D.O.B.: ________________

Address ____ Postal Code ________________

Phone ______________________________ Email ______________________________________

Occupation _____________________ Allergies ____

Emergency Contact

Name __________________________________ Phone _________________________________

MEDICAL TEAM CONTACT DETAILS				
	Name	Clinic Name	Phone Number	Fax number
Usual GP				
Oncologist				
Surgeon				
Other (Haematologist/ Urologist/Care Nurse)				

How did you hear about us?

____

Do you suffer from, or have you had a history of any of the following conditions? (Please ☑)

- ☐ Chest pain/discomfort
- ☐ Dizziness, feeling faint or blacking out
- ☐ Known heart murmur/condition
- ☐ Ankle swelling
- ☐ Bone Metastases
- ☐ Shortness of breath with minimal exertion
- ☐ Palpations/irregular heart beat
- ☐ Leg/calf pain with exercise (claudication)
- ☐ Stroke
- ☐ Low blood count

Please ensure your treating physician is aware of any of these symptoms should you experience them.

Please tick the box corresponding to any of the following that apply to you (Please ☑)

- ☐ High blood pressure
- ☐ Asthma/respiratory disorder
- ☐ Joint problems
- ☐ Pregnancy or recent birth
- ☐ Osteoporosis or low bone density
- ☐ High cholesterol
- ☐ Anxiety/depression
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Vision/hearing loss
- ☐ Tobacco smoking (past/present)
- ☐ Diabetes Mellitus (insulin/non-insulin)
- ☐ Family history of heart disease
- ☐ Lymphedema
- ☐ Had a fall in the past 12 months

If you ticked any of the boxes above, please provide details here:

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CANCER RELATED QUESTIONS:

Primary Cancer Diagnosis: ____Stage:_________________ Grade: _______________

Date of diagnosis: _____________________Metastases (if bone please provide scan report)______________________________

Surgery details: ____

Chemotherapy details: ____

Radiation details: ____

Hormone therapy details: ____

Transplant details: ____

Current Cancer situation: (in remission, reoccurrence, completed treatment, currently undergoing treatment)

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Please give details of any residual side effects, such as: heart problems, fatigue, peripheral neuropathy, low bone density, lymphedema, chronic diarrhoea or vomiting?

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Is there anything you can't do now that you use to be able to do?

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Do you have any other bone, joint, medical conditions or previous surgery?

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____

Current Medications	
Medication Name	Reason for taking it

Do any of your medications affect your immune system or your heart rate?

____

FATIGUE INDEX

0	1	2	3	4	5	6	7	8	9	10

No fatigue Extreme fatigue

PERCEIVED LIFE STRESS LEVEL

1: NONE	2: LIGHT	3. MODERATE	4: HIGH	5: EXTREME

Pre cancer exercise history: Type/frequency/intensity

____

____

Current exercise/activity: Type/frequency/intensity

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What do you hope to achieve by coming to see an Exercise Physiologist?
Please rate these goals as to how important they are to you by giving them a score out of 10.

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STATEMENT:
I acknowledge that the information I have given above is true and accurate. I give Moving Beyond Cancer permission to discuss my medical history with my treating practitioners.

Signed: _____________________________________ Date: ____________________