**For the Patient**: Please complete with assistance as required and take to your GP for signature.

MULTICULTURAL HEALTH SERVICE Location

Please return this form to Programme Coordinator at the Multicultural Health service

Phone number:

|  |
| --- |
| PRE-ACTIVITY QUESTIONAIRE CONFIDENTIAL |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Birth Date\_\_\_/\_\_\_/\_\_\_\_ Sex M/F

Adress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_postcode\_\_\_\_\_\_

Phone (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Mob)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Bus)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD OR DO YOU HAVE?

Section A

|  |  |  |  |
| --- | --- | --- | --- |
| High Blood Pressure | Yes/No | Stomach/Duodenal Ulcer | Yes/No |
| Low Blood Pressure | Yes/No | Liver/Kidney condition | Yes/No |
| High Cholesterol/Triglycerides | Yes/No | Diabetes | Yes/No |
| Paint/tightness in the chest | Yes/No | Epilepsy | Yes/No |
| Rheumatic Fever | Yes/No | Hernia | Yes/No |
| Any Heart/Stroke condition | Yes/No | Depression or anxiety |  |
| Osteoporosis | Yes/No | Breathing difficulties or Asthma | Yes/No |
|  |  | Arthritis | Yes/No |

Section B

|  |  |
| --- | --- |
| - A family history of heart disease, stroke or raised cholesterol of relatives under age 65? | Yes/No |
| - Do you smoke cigarettes/pipe/cigar? | Yes/No |
| - How much alcohol do you drink each day or week? |  |
| - Do you have muscular pain/cramps? | Yes/No |
| - Have you had any major injuries?  Please describe | Yes/No |
| - Have you exercised before?  How often? How recently? | Yes/No |

Section C

|  |  |
| --- | --- |
| - Have you had any major surgery?  If so, how long ago and describe? | Yes/No |
| - Do you have or have you had recently any infections or infectious diseases?  Please describe | Yes/No |
| - Are there any other conditions or illnesses, which may limit your activity program?  Please describe | Yes/No |

Section D

|  |  |
| --- | --- |
| Pain location(s) |  |
| Pain present for | 3-6 months ⃝ 6-12 months ⃝ 1-2 years ⃝ 2-5 years ⃝ More than 5 years⃝ |
| Type of pain | Burning ⃝ ache ⃝ constant ⃝ intermittent ⃝ |
| How did your main pain begin? | After surgery ⃝ Motor Vehicle crash ⃝ Injury at work/school ⃝ related to cancer ⃝ Other ⃝ |

**For GP to complete**

|  |  |
| --- | --- |
| List all the medications taken (include all prescription, traditional and over-the-counter medicines) |  |
| Medicine name (as on the label) | Medicine strength (as on the label) and dose |
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In my opinion, there is no medical reason why I should not take part in the exercise program.

I understand that all safety precautions will be observed and I accept that there is a small risk associated with undertaking any exercise program. I have completed this form and I understand it. I will notify the Multicultural Health Worker and my instructor of any changes to my health by completing a new questionnaire.

SIGN PARTICIPANT:…………………………………………………………………….DATE:……………………………………………….

SIGN WITNESS:……………………………………………………………………………DATE:……………………………………………...

I give my consent for the service to contact my GP…………………………………………………..

\* **Please have this form signed by a GP or health professional if you have answered yes in section A.**

HEALTH PROFESSIONAL APPROVAL Signed:…………………………………….Date:……………………………..

Health Professional Title e.g. General Practitoner/Physiotherapist:……………………………………………………

Name………………………………………………………………..Contact Ph:……………………………………………………………

Address……………………………………………………………………………………………………..Postcode:……………………..

Published Oct 2017. ACI/D23/888 © State of NSW (Agency for Clinical Innovation)