Conquer
ALLIED HEALTH

Conquer Allied Health Pre-Exercise Screening

PERSONAL DETAILS

Name: …… Age: …… DOB: …… M / F
Address: ……
Phone Home: …… Mobile: …… Email: ……
Emergency Contact Person: …… Phone: ……
Relationship to you: …… Funding Scheme: NDIS or White or Gold DVA

1. Do you have, or have you had:

☐ Heart disease (please specify)
……
☐ High Blood Pressure or High Cholesterol
☐ Diabetes
☐ Lung disorder (e.g., Asthma, emphysema)
……..
☐ Other cardiac problem (incl. pacemaker,):
……
☐ No/ or none of the above.

2. Have you ever been told you are at risk of?

☐ Heart disease ☐ High Blood Pressure
☐ High cholesterol ☐ Diabetes / Stroke
☐ No/ or none of the above

3. Have you ever been told that you have heart problems, e.g.?

☐ Heart murmur ☐ Valve defect
☐ Racing Heart ☐ Irregular beats
☐ Angina
☐ No/ or none of the above.

4. Do you have, or have you experienced:

☐ Epilepsy ☐ Fainting ☐ Seizures
☐ Dizzy spells ☐ Convulsions
☐ No/ or none of the above.

5. Do you experience sudden shortness of breath?

☐ Yes No

6. Have you ever had pain or pressure, either at rest or during exercise:

☐ In the middle of, or on the left side of, the chest.
☐ In the neck region.
☐ At the left shoulder or down the left arm.
☐ No/ or none of the above.

7. Do you take any medications for (Please name):

☐ Heart disease: ……
☐ Diabetes: ……
☐ Cholesterol: ……
☐ Blood pressure: ……
☐ Asthma, breathing problems: ……
☐ Other……
☐ No/ none of the above.

8. Are you aged over 60 years of age:

☐ Yes No

9. Do you have any joint or muscular problems that may affect your ability to train:

☐ Yes No

If yes, please explain……
……
……

10. What is your primary diagnosis?

Please explain……

Other diagnosis?

……

Previous Treatment?

……

Answered yes to more than 5, MEDICAL CLERANCE REQUIRED.

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MUSCULOSKELETAL Any pain or major injury to: (Please tick any which apply) ☐ Feet / Ankles ☐ Calf / Shin / Achilles ☐ Hamstring / Gluteus ☐ Hips / Groin ☐ Lower back / Abs ☐ Upper back / Ribs ☐ Neck / Shoulders ☐ Arms / Elbow ☐ Wrist / Elbow	How did you injure yourself? _____ When did you injured yourself? _____ Did you hear anything? _____ What was the initial treatment? _____ Scale of a 10, how painful is it? _____ What type of pain do you experience e.g., sharp, Niggle etc.? _____ What time of the day do you experience pain? _____ Do you take any medications to manage pain? _____ In what position do you sleep? _____ Are you currently doing any activity? _____
What is your diet is like? 	How would you describe your diet? _____ What does a healthy diet look like to you? _____ What did you have for breakfast? _____ How many servings of fruits and vegetables do you have per day? _____ How often do you eat fish? _____ What medications are you taking? _____ Are you a drinker? _____

Goals and Current Exercise Habits	
What do you hope to achieve from your fitness program? Please tick	
☐ Lifestyle change (Improve health)	☐ To gain overall fitness
☐ To improve aerobic fitness	☐ To tone up
☐ To gain muscular strength	☐ To gain muscular power
☐ Sport specific	☐ Other: _____

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		Risk Factor
1. Age Gender	≥45yrs males or ≥55yrs females +1 risk factor	
2. Family history of heart disease (e.g., stroke, heart attack). Relative Age Age ☐ Father ___ ☐ Mother ___ ☐ Brother ___ ☐ Sister ___ ☐ Son ___ ☐ Daughter ___	If male <55yrs = +1 risk factor If female < 65yrs = +1risk factor Maximum of 1 risk factor for this question	
3. Do you smoke cigarettes on a daily or weekly basis, or have you quit smoking in the last 6 months? Yes No If currently smoking, how many per day or week?	If yes, (smoke regularly or given up within the past 6 months) = +1 risk factor	
4. Describe your current physical activity/exercise level: Please circle one. Sedentary Light Moderate Vigorous Frequency Sessions per week ___ _____ _____ Duration Minutes per week ___ _____ _____	If physical activity level <150 min/week = 1 risk factor If physical activity level >150 min/week = -1 risk factor (Vigorous physical activity/exercise weighted x2).	
5. Please state your Height (cm) _____ Weight (cm) _____	BMI =_____ BMI > 30kg/m^2= +1 risk factor	
6. Have you been told that you have high blood pressure? Yes No	If yes, = +1 risk factor	
7. Have you been told that you have high cholesterol? Yes No	If yes, = +1 risk factor	
8. Have you been told that you have high blood sugar? Yes No	If yes, = +1 risk factor	
Note: Refer over page for risk stratification.	STAGE 2 Total Risk Factors =	

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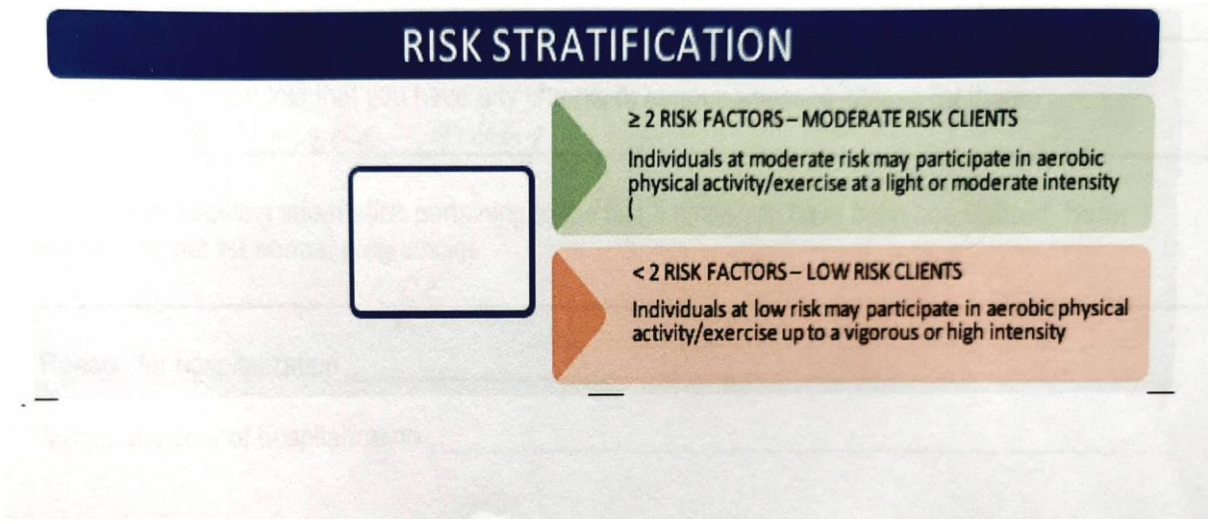
STAGE 3

AIM: To obtain pre-exercise baseline measurements of other recognized cardiovascular and metabolic risk factors. This stage is to be administered by a qualified exercise professional.

	Results		RISK FACTORS
1. BM (kg/m^2) Skinfold%		BM >30kg/m^2 = +1 risk factor	
2. Waist girth (cm)		Waist >94 cm for men and >80 cm for females = +1 risk factor	
3. Resting blood pressure (mmHg)		SBP >140 mmHg or DBP >90 mmHg = +1risk factor	
4. Cholesterol (mmol/L)		Cholesterol >5.20 mmol/L = +1 risk factor	
5. Blood Glucose (mmol/L)		Blood Glucose >7.8mmol/L = +1 Diabetes >10mmol/L = +1	

STAGE 3 Total Risk Factor =

PLEASE ADD UP RISK FACTOR SCORE



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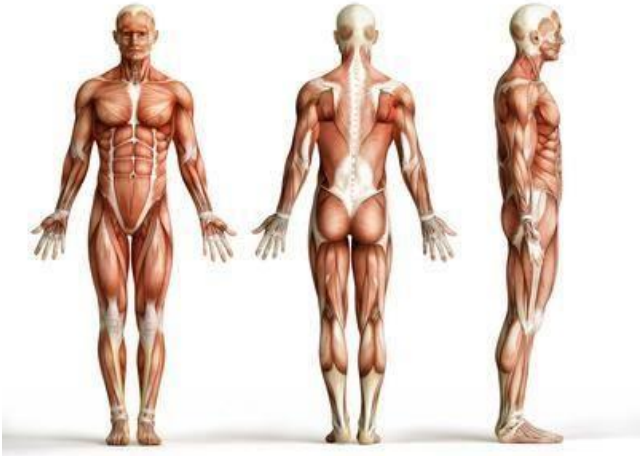
Full Body Postural Analysis



Front View			Back View	
☐ Head Tilted			☐ Head Tilted	
☐ Forward Neck			☐ Forward Neck	
☐ Shoulder Height			☐ Shoulder Height	
☐ Rounded Shoulder			☐ Winging of the Scapula	
☐ Acromion Process Palpation			☐ Upper Back Symmetry	
☐ Clavicle Joint			☐ Elbow Line	
☐ Sternoclavicular spine palpation			☐ Lower Back Symmetry	
☐ Nipple Align			☐ Posterior Pelvic Tilt	
☐ Chest Symmetry			☐ PSIS more Prominent	
☐ Elbow Distance to Body ☐ Elbow line			☐ Gluteal Symmetry	
☐ Distance from Fingertip to floor			☐ Hamstring Symmetry	
☐ Ribs More Prominent			☐ Genu Recurvatum	
☐ ASIS More Prominent			☐ Calf Symmetry	
☐ Anterior Pelvic Tilt			☐ Any swelling or deformity	
☐ Quad Symmetry			**Side View**	
☐ Knee Alignment			☐ 5-Point Line	
☐ Genu Valgum			☐ Forward Neck & Head	
☐ Genu Varus			☐ Chest Visible	
☐ Calf Symmetry			☐ Rounded Shoulder	
☐ Pes Planus			☐ Kyphosis	
☐ Pes Cavus			☐ Lordosis	
☐ Any swelling or Deformities			☐ Sway Back/Flat back	

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Mental Health Questionnaire

Over the past 2-weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interested in pleasure in doing this.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching the television.	0	1	2	3
8. Moving or speaking so slowly, that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
Column Totals Total score: (Columns added together) _____				
10. If you have checked of any problems, how difficult have those problems made it for you to, do your work, take care of things at home, or get along with other people.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Score:	5-9 Minimal symptoms.	10-14 Minor depression	15-19 Major Depression
More than 20, major depression refers to health care provider			

Medical History Questionnaire

1. When was the last time you had a physical examination? _____
2. If you are allergic to any medications, foods, or other substances, please name them.
   _____
3. If you have been told that you have any chronic or serious illnesses, please list them.
   _____
4. Give the following information pertaining to last 3 times you have been hospitalized.
   Note: Women, do not list normal pregnancies. _____
   Reason for Hospitalization _____ Date and Year _____

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INFORMED CONSENT

In order to assess cardiovascular function, body composition, and other physical fitness components, the undersigned hereby consents to engage in one or more of the following tests (check the appropriate boxes):

- ☐ Body composition tests
- ☐ Muscle fitness tests
- ☐ Flexibility tests
- ☐ Balance tests

The exercise intensity will begin at a low level and will be advanced in stages depending on your fitness level. We may stop the test at any time because of signs of fatigue or changes in your heart rate, electrocardiogram (ECG), or blood pressure. It is important for you realize that you may stop when you wish because of feelings of fatigue or any other discomfort.

ATTENDANT RISKS AND DISCOMFORTS

There exists the possibility of certain changes occurring during the tests. These changes include abnormal blood pressure, fainting, irregular, fast, or slow heart rhythm, and in rare instance, heart attack, stroke, or death. In addition, some tests carry a risk of muscle tears and soreness. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during testing.

RESPONSIBILTIES OF THE TESTER

- To ensure safe and appropriate protocol and procedures and followed.
- To ensure testing protocols able to be justified in terms of current scientific literature.
- To ensure confidentiality of client's data and private information.
- To maintain client interest and welfare as the highest priority.

RESPONSIBILTIES OF THE PARTCIPANT

- To fully disclose information relating to personal health status.
- To report information relating to previous experiences as unusual feelings with physical effort.
- To promptly report unusual feelings or discomfort during the test.

BENEFITS

Results obtained from this exercise test may assist in:

- The determination of your specific response to exercise.
- The prescription of exercise to enhance your performance.
- An evaluation of physical activities that you might do with low risk.

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DRESS REQUIREMENTS

- Comfortable shorts/pants and short-sleeved or sleeveless top.
- Running shoes (clients are asked to no wear mud-caked shoes).

BEFORE THE TEST

- Avoid solid food in the two-hour period before the test.
- Avoid caffeine beverages for two hours prior to the test.
- Clients should not smoke during the two hours prior to the test.
- Exercise should be avoided for six hours before the test.
- Avoid alcoholic drinks for at least six hours prior to the test.

INQUIRIES

If you have any concerns or questions, please ask us for further explanations.

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INFORMED CONSENT FOR AN EXERCISE TEST

Name:	
You will perform the following exercise test/s:	Please refer to assessment form.
The equipment used for your test/s will include	Please refer to assessment form.

Freedom of Consent

- **Your permission to perform this exercise test is voluntary. You are free to stop the test at any point if you so desire.**

- **I have read this form and I understand the tests procedures that I will perform and the attendant risks and discomforts.**
- **Knowing these risks and discomforts and having had the opportunity to ask questions that have been to my satisfaction, I willingly consent to participate in this test.**

Client Signature /Date	Tester's signature /Date