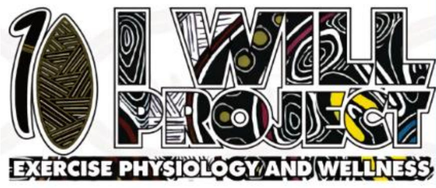


Date: ___________________

Patient ID: _______________

SESSION 1

I WILL Participant Assessment

Participant Details

- ☐ **Face to face**
- ☐ **Telehealth**

Name: _______________________________________ DOB: ____/____/____ Age:______ Gender M/F/O
Address: ____
Phone: ____
Email:____
Medicare card No: _________________________IRN: ____
Private health Fund: ________________________No: ____
Emergency Contact (Name/phone): ____

Care Team

GP: _________________________Clinic/Hospital: ______________________Phone: __________________
Aboriginal Medical Service Name: ___________________________________ Phone: __________________
AMS: Chronic Care Coordinator Name: ______________________________ Phone: __________________

- ☐ Have you completed a 715 Aboriginal Health care check in the past 12 months?
- ☐ Are you up to date with your cancer prescreening?
- ☐ Have you ever been diagnosed with cancer?
- ☐ Prior to diagnosis were you regularly exercising?
- ☐ If in active treatment, consult with GP/specialist prior to exercise.
- ☐ Medical clearance pending
- ☐ Medical clearance obtained Date____/____/____,

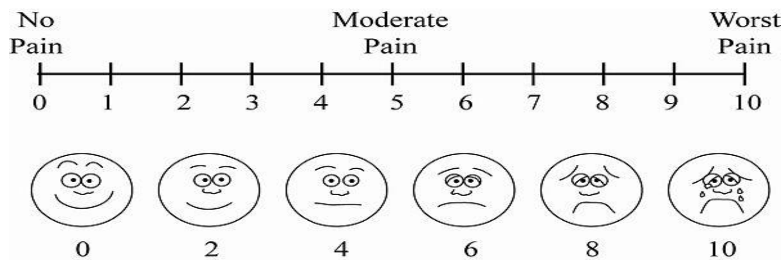
Care History: Please list any non-cancer diagnoses or hospitalizations you have in the past ten years, and describe any health concerns you may have that could be undiagnosed?

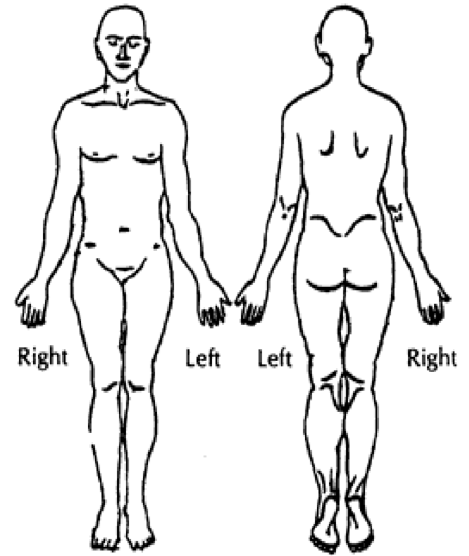
____
____
____

Are you currently on any medication? Dosage/frequency. Please supply your clinician with a copy of your medication schedule.
____ ____ ____

Pain and Distress

Using the charts below, please indicate any pain or fatigue you are experiencing and where about on your body these symptoms present.





What makes your pain or fatigue better or worse?

____

____

What time of day do you feel you are at your best? And worse?

____

____

Lifestyle

Do you consume alcohol? If yes how many drinks would you have each week and what kind?

____

Do you smoke? If yes how many cigarettes per day?

____

Nutrition

Prior to diagnosis, what would you regularly eat for

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

What are you regularly eating now?

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Exercise

Do you enjoy exercise? If so what kinds? ____

Frequency	Intensity	Type	Time

Are you currently exercising?

Frequency	Intensity	Type	Time

Goal Setting

Please talk to me about your goals

Short Term (now till 12 weeks) ____
Medium Term (3-6 months) ____
Long term (6-12months) ____

What barriers that may prevent you from achieving your goal?

____
____

What enablers do you have access to that may support you to achieve your goal?

____
____

Clinicians Recommendations

Starting Exercise Advise

- ☐ GP/Specialist Exercise Clearance Requested
- ☐ Exercise Intensity RPE: ___________________________
- ☐ Walking ExRx:____
- ☐ Resistance Training; ExRx:____
- ☐ Hydrotherapy: ____
- ☐ Low intensity Yoga/Tai Chi/TheraBand Program

Daily Nutritional considerations

- ☐ Vegetables 2-3 serves.
- ☐ Lean meat Fish/chicken/lean red meat 2 serves.
- ☐ Quality Starchy carbs 2 serves.
- ☐ Fruit and vegetables high in antioxidants 2-3 serves.
- ☐ Refer to Dietician if weight loss or weight gain <5% in 3 months

Other Considerations

- ☐ Protein requirements
- ☐ Iron Injection
- ☐ B12 Injection
- ☐ Creatinine
- ☐ Other ___________

Social Support, referred to

- ☐ AMS Chronic Care Program
- ☐ Men’s/woman’s cancer support group
- ☐ Refer to Men’s/woman’s business program
- ☐ Refer to Local hospital social worker

Next Appointment (Date/time): ____

GYM WALK THROUGH Q&A

Participant Outcomes Measures

Name:		**Gender:**	**Age:**	
Height:	BMI:	Risk Category	BP:	HR:
Weight:	WHR:	Risk Category	T score if known	Cancer Related QOL Score

Outcome Measures Assessment Tools

<table>
<tr><th>Test</th><th>Flexibility</th><th>Balance</th><th>Mobility</th><th>Cardiovascular Endurance</th><th>Strength</th></tr>
<tr><td rowspan="2">Outcome Measures</td><td>Sit and Reach

1.
2.
3.
Avg:</td><td>4 Square Balance Test

1.
2.
3.
Avg:</td><td>3m Timed Up and Go
1.
2.
3.
Avg:</td><td>6-minute Walk Test

Distance:</td><td rowspan="2">5x Sit to stand.

2kg Arm Curl
R:
L:

30sec Pushups:
☐ Floor
☐ Modified
____

Total:</td></tr>
<tr><td>Back Scratch

R:
L:</td><td>Functional Reach

R:
L:</td><td>10m Walk

Pace:</td><td>Sub max Vo2

Modified Bruce Treadmill Test</td></tr>
</table>

- *Exercise and Sports Science Australia (ESSA) 2017, Exercise and Sports Science Australia's Outcome Measures for Exercise Physiologists, Ensuring evidence Based Practice. Marlow, Hastings & Hansson.*

All About You

Tell me about life before your diagnosis? Family/children/activities of interest

____

____

____

Are you currently working? How do you support yourself? ________________________________

As of right now what's important to you? ______________________________________

What are your hobbies/interests? ____

How to do take care of yourself? ____

Do you have any worries? What concerns you most?

____

Cancer History

Oncologist: _______________ Clinic/Hospital: __________________Phone: _______________

Family Cancer History	☐ Mother Type: ______________________________ ☐ Father Type: ______________________________ ☐ Sister/brother Type: __________________________

Participant Cancer History

Primary Cancer Site		Remission Cancer Free Yrs.	☐ Yes ☐ 1-2 ☐ 2-4 ☐ >5
Secondary Cancer Site		Bone Tumor Site	☐ Hip/pelvis. ☐ Spine ☐ Femur ☐ Other ___________

Tx to Date	☐ Surgery	Location:	Date Start:	End:	In Active Treatment ☐
	☐ Radiation Therapy	Location:	Date Start:	End:	☐
	☐ Chemotherapy ☐ PIC/Port Location		Date Start:	End:	☐
	☐ Immunology/Targeted		Date Start:	End:	☐

	Watchful waiting
	☐ Planned Future treatment
	☐ Other

Treatment side effects:

Surgery	☐ Wound healed	Location:	
Lymphoedema	☐	Location:	
Anaemia Low RBL	☐ Fatigue ☐ Low RBC	Cachexia Sarcopenia	☐ BW ↓5% ☐ Muscle weakness/loss
Thrombocytopenia Reduced clotting	☐ Bruising/bleeding	T Score/Bone loss	☐ -1 Mod ☐ -2.5 Severe
Neutropenia Reduced immunity	☐ Colds/flu/Covid	Pain: VAS	☐ 0-5 ☐ 5-10
Musculoskeletal	☐ Joint pains ☐ Weakness ☐ Balance/falls	Fatigue VAS	☐ 0-5 ☐ 5-10
Fever	☐	Cellulitis	☐
Dizziness	☐ Mod ☐ Mild ☐ Severe	Peripheral Neuropathy	☐ Vision ☐ Feet ☐ Hands ☐ Legs ☐ Balance issues
Memory impairment	☐ Poor ☐ Average ☐ Ok	Chest pain	☐ Date _________
Sleep	☐ <8hrs	Avg sleeping hrs.:	
Sexual Function	☐ Reduced interest	Mental Health	☐ Anxiety ☐ Depression ☐ Other Dx:
Gastro Health	☐ Nausea ☐ Incontinence ☐ Diarrhea ☐ Constipation		
Skin disorders	☐ Shingles ☐ Dry/Flaky	Oral Health issues	☐ Teeth ☐ Gums ☐ Lips
Other	Please list or describe any other issues the patient may be experiencing that needs consideration of investigation.		