LM-67

Personal details

Full name: _____ Date of birth: DD / MM / YYYY Sex (M/F): ___

Date: DD / MM / YYYY

Relationship status: ☐ Single ☐ Married ☐ De facto ☐ Coupled ☐ Divorced ☐ Widowed

Employment status: ☐ Full-time ☐ Part-time ☐ Casual/temporary ☐ Contract ☐ Not employed

☐ Carer ☐ Homemaker

Occupation (most recent if retired/unemployed): _____

Are you retired? ☐ Yes ☐ No Date of retirement: DD / MM / YYYY

Do you have a disability? ☐ Yes ☐ No Date of disability: DD / MM / YYYY

Highest level of education: _____

Please list any medications (including supplements) you are currently taking:

_____

_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please describe: _____

Please list any relevant family medical history:

_____

_____

General health

1. In **general**, how would you rate your overall health?

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Sleep

2. Do you work day shifts, night shifts, or a combination of both? Please tick all which apply.

   ☐ Day shift ☐ Night shift ☐ N/A

3. Over the past month, have you had a major stressful event that you feel affected your sleep? If so, please describe: _____

For the questions below, please check the **one** box that best describes you, and/or describe your response on the line provided.

During the **past 4 weeks**, how often:

4. Did you have difficulty falling asleep, staying asleep, or feel poorly rested in the morning?

   ☐ Never ☐ Sometimes ☐ Usually ☐ Always

5. Did you fall asleep unintentionally or have to fight to stay awake during the day?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

6. Did sleep difficulties or daytime sleepiness interfere with your daily activities?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

7. Did work or other activities prevent you from getting enough sleep?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

8. Did you snore loudly?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

9. Did you hold your breath, have breathing pauses, or stop breathing in your sleep?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

10. Did you have restless or 'crawling' feelings in your legs at night that went away if you moved your legs?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

11. Did you have repeated rhythmic leg jerks or leg twitches during your sleep?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

12. Did you have nightmares, or did you scream, walk, punch or kick in your sleep?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

13. Did any of the following things disturb you in your sleep?

a. Pain ☐ Never ☐ Sometimes ☐ Usually ☐ Always

b. Other physical problems ☐ Never ☐ Sometimes ☐ Usually ☐ Always

c. Worries ☐ Never ☐ Sometimes ☐ Usually ☐ Always

d. Medications ☐ Never ☐ Sometimes ☐ Usually ☐ Always

e. Other (please specify) ☐ Never ☐ Sometimes ☐ Usually ☐ Always

_____

14. Did you feel sad or anxious?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

Physical activity

Incidental activity

15. Of the responses below, which best describes the physical activity in your work? Tick **one**.

    ☐ I am not currently in employment (retired, retired for health reasons, unemployed, full-time carer, etc.)

    ☐ I spend most of my time at work sitting (such as in an office)

    ☐ I spend most of my time at work standing or walking, but my work does not require much intense physical effort (shop assistant, hairdresser/barber, security guard, childminder, etc.)

    ☐ My work involves physical effort, including handling of heavy objects and use of tools (plumber, electrician, carpenter, cleaner, nurse, gardener, etc.)

    ☐ My work involves vigorous physical effort, including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)

Aerobic exercise

16. **On average**, how many days per week do you engage in moderate-intensity physical activity?

    This is an activity that requires some effort, but where a conversation is possible (e.g. a brisk walk).

    _____ days

17. **On average**, how many minutes per day do you exercise at this intensity?

    _____ minutes

18. List the types of aerobic activity that you do (walking, running, swimming, cycling, dancing etc.)

    _____

Strength and resistance training

19. **On average**, how many days per week do you engage in strength or resistance training?

    This includes activites such as lifting weights, resistance bands and some forms of yoga.

    _____ days

20. **On average**, how many minutes does a session last?

    _____ minutes

21. List the types of strength or resistance training activities that you do (weights, yoga, resistance bands, etc.)

    _____

Weight management

22. What is the most you have ever weighed since reaching your current height? Exclude any weight gains due to medical conditions or medications:

    _____ kg

23. What is your current weight?

    _____ kg

24. Are you currently on a diet?

    ☐ Yes ☐ No

    If **no**, go to question 26

25. Are you currently dieting to lose weight or to avoid gaining weight?

☐ To lose weight ☐ To avoid gaining weight

26. Please estimate, as best you can, the number of times in your life that you have dieted and deliberately lost the amounts of weight listed below:

1-2 kg? _____ times

2-5 kg? _____ times

5-10 kg? _____ times

10+ kg? _____ times

Diet and nutrition

27. How many serves (see below) of fruit do you **usually** eat each day?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ I don't eat fruit

Each of the above represents a single serve of fruits and provides about 350 kilojoules.

28. How many serves (see below) of vegetables do you **usually** eat each day?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ I don't eat vegetables

Each of the above represents a single serve of vegetables and provides 100-350 kilojoules.

29. In an average week, how many serves (see below) of discretionary foods do you **usually** eat each day?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ I don't eat these foods

Each of the above represents a single serve of discretionary foods and provides 500-600 kilojoules.

30. In an average week, how many serves (see below) of soft drinks, cordials, sports drinks, caffeinated energy drinks or other sugar-sweetened beverages do you **usually** drink each day?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ I don't drink these beverages

Each of the above represents a single serve of sugar-sweetened beverages and provides 500-600 kilojoules.

Mental health

31. In the past 4 weeks (tick one box per row):

	None of the time	A little of the time	Some of the time	Most of the time	All the time
1. About how often did you feel tired out for no good reason?					
2. About how often did you feel nervous?					
3. About how often did you feel so nervous that nothing could calm you down?					
4. About how often did you feel hopeless?					
5. About how often did you feel restless or fidgety?					
6. About how often did you feel so restless you could not sit still?					
7. About how often did you feel depressed?					
8. About how often did you feel like everything was an effort?					
9. About how often did you feel so sad that nothing could cheer you up?					
10. About how often did you feel worthless?					

Stress

32. In the last month, how often have you felt that you were unable to control the important things in your life?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

33. In the last month, how often have you felt confident in your ability to handle your personal problems?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

34. In the last month, how often have you felt that things were going your way?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

35. In the last month, how often have you felt difficulties piling up so high that you could not overcome them?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

36. How do you cope with stress? Circle all that apply.

Exercise	Smoking cigarettes	Gambling
Yoga	Using drugs	Spiritual or religious activities
Massage	Guided imagery	Seeking out friends or family
Deep breathing	Progressive muscle relaxation	Counselling/therapy
Drinking alcohol	Meditation	Eating too much/too little

Other: _____

Resilience

37. Tick one box per row:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I tend to bounce back quickly after hard times					
2. I have a hard time making it through stressful events					
3. It does not take me long to recover from a stressful event					
4. It is hard for me to snap back when something bad happens					
5. I usually come through difficult times with little trouble					
6. I tend to take a long time to get over setbacks in my life					

Connection

38. How satisfied are you with the quality of relationships you have with friends/family?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

39. How satisfied are you with the number of friends/acquaintances you have?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

40. How satisfied are you with the extent to which you feel like a member of the community?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

Purpose

41. Tick the box in each row that best describes your present agreement or disagreement with each statement:

	Strongly disagree	Disagree somewhat	Disagree slightly	Agree slightly	Agree somewhat	Strongly Agree
1. I live one day at a time and don't really think about the future						
2. I have a sense of direction and purpose in life						
3. My daily activities often seem trivial and unimportant to me						
4. I don't have a sense of what it is I'm trying to accomplish in life						
5. I enjoy making plans for the future and working to make them a reality						
6. Some people wander aimlessly through life, but I am **not** one of them						
7. I sometimes feel as if I've done all there is to do in life						

Substance use

Tobacco

42. Do you smoke?

    ☐ Yes ☐ No

43. Have you ever smoked? If **no**, go to question 53.

    ☐ Yes ☐ No

44. If **yes**, how long ago did you quit? Fill in and circle:

    _____ days/months/years

45. How many minutes after you first wake up in the morning do you smoke your first cigarette?

    _____ minutes

46. How many cigarettes do you smoke in a day?

    _____ cigarettes

47. Have you tried to quit before?

    ☐ Yes ☐ No

48. Have you used any medications to help you quit smoking? If yes, please list:

    ☐ Yes ☐ No

    Medications used: _____

49. Have you used any methods other than medications to help you quit? If yes, please describe:

    ☐ Yes ☐ No

    Methods used: _____

50. What cravings or withdrawal symptoms did you experience in previous quit attempts? Please describe.

    _____

51. How do you feel about your smoking at the moment?

    ☐ Does not worry me ☐ Worries me

52. Are you ready to stop smoking?

    ☐ Yes ☐ Yes, but not now ☐ No

Alcohol

53. Have you ever felt the need to cut down on your drinking?

    ☐ Yes ☐ No

54. Have people annoyed you by criticising your drinking?

    ☐ Yes ☐ No

55. Have you ever felt guilty about your drinking?

    ☐ Yes ☐ No

56. Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or get rid of a hangover?

☐ Yes ☐ No

57. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week

☐ 4 or more times per week

58. How many drinks containing alcohol do you have in a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

59. How often do you have 4 or more standard drinks on one occasion (see below)?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

The following are examples of the number of standard drinks in some typical alcoholic beverages. A standard drink is any drink that contains 10 grams of alcohol:

Small glass of beer: full strength (pot/middy)
285mL 4.8%

Large glass of beer: full strength (schooner)
425mL 4.8%

Bottles & cans of beer: full strength
375mL 4.8%

Ave. restaurant serving of red wine
150mL 13.5%

Ave. restaurant serving of white wine
150mL 11.5%

Straight spirits
30mL 40.0%

Ready to drink spirits: full strength
275mL 5.0%

Pre-mixed spirits: full strength
375mL 5.0%

Drugs

60. In the last 12 months, have you used recreational drugs (e.g. marijuana, ecstacy/MDMA, cocaine, methamphetamine) or misused prescription drugs? If no, please skip to question 64.

    ☐ Yes ☐ No

61. In the last month, how often have you used recreational drugs or misused prescription drugs?

    ☐ More than once a week ☐ Less than once a week

62. In the last month, have you used multiple recreational drugs or prescription drugs at the same time?

    ☐ Yes ☐ No

63. In the last month, have you used recreational drugs or misused prescription drugs alone/by yourself?

    ☐ Yes ☐ No

Ready to change?

64. If you could change **one** thing about your life, what would it be?

    _____

    _____

    _____

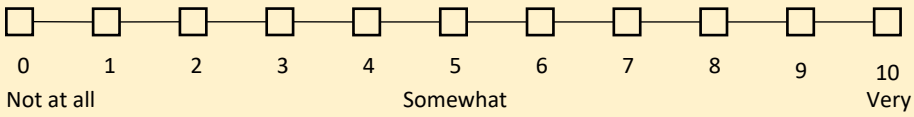
65. What are the most important lifestyle areas you wish to make changes in (if any)? List three and rank from 1-3 in importance:

    _____

    _____

    _____

66. For each of the three lifestyle areas you wish to make changes, how **important** are these changes to you right now? Place the numbers 1-3 in the relevant boxes.



67. How **confident** are you about making these changes? Place the numbers 1-3 in the relevant boxes