Pre-activity & Medical questionnaire
For participation in: Personal Training / Small Group / Boxing Sessions

Name:_____

Date of birth:_____ Age:_____

Address:_____

Phone:_____

Emergency Contact:_____ Phone: _____

Which exercise session would you like to participate in? *(Please tick the box of the session you are interested in)*	
Small group training Circuit format of warmup, cardio, strength training, cool down and stretch 1 hour duration, 2-6 participants per class Sessions: Monday, Wednesday & Friday mornings	
Personal training One on one with a qualified personal trainer Each session is based on the individual goals of the participant 1 hour duration, Times by appointment	
Boxing Circuit format of warmup, pad and bag punching, cool down and stretch 45-minute duration, maximum of 8 participants per class Time: Thursday 1.30 – 2.30 pm	

Current physical activity

✓ if more than 15 mins

Activity	Once/week	Some days	Most days	Every day
Walking				
Exercises at home/gym				
Gardening				
Swimming or aqua aerobics				
Yoga				
Tai Chi or Chi Ball				
Dancing				
Bowls				
Cycling				
Other -				

Previous experience using gym or boxing equipment (if applicable)

_____

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MEDICAL INFORMATION

Have you been diagnosed with or previously suffered from any of the following?

	Yes	No
Heart attack, coronary revascularization surgery or stroke?		
Chest pain, especially during exercise?		
Feel faint or have severe dizziness, especially during exercise?		
High or low blood pressure?		
Neurological condition e.g. acquired brain injury, dementia, epilepsy, multiple sclerosis, Parkinson's?		
Liver, kidney, thyroid or gastrointestinal disorders?		
Respiratory condition e.g. asthma, COPD?		
Diabetes type 1 or 2?		
Joint problems e.g. Arthritis, osteoporosis, joint replacements?		
Have you undergone surgery in the past 6 months?		
Do you take any medication (prescription or other) that may affect your ability to exercise?		
Any other physical problem that requires clarification from a health professional?		

If you ticked yes for any of the above, please answer the following questions.

What medical condition(s) do you currently have and in what year was the condition diagnosed?

_____

_____

_____

_____

The physical symptoms I experience most are:

☐ Slowness of movement ☐ Tremor ☐ Rigidity/stiffness ☐ Lack of coordination

☐ Problems with balance ☐ Vision issues ☐ Other: (please elaborate)

_____

_____

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What medication (s) do you currently take and can the medication (s) effect your ability to exercise?

_____

_____

_____

_____

Is there any other information you would like to provide about your current wellbeing that may assist us to ensure that you have a safe and enjoyable exercise session?

_____

_____

_____

_____

What do you hope to achieve from your exercise program?

_____

_____

I acknowledge that I participate in the class at my own risk and it is my responsibility to obtain approval from my doctor for any medical conditions that may affect my safety or health.
I will also ensure that the instructor is fully aware of all such conditions at the commencement of the program and any subsequent change (s) in my medical condition (s).
I agree to exercise within my comfort levels and if discomfort arises, to modify or cease that activity and inform the instructor.

Signature: _____ **Date:** __/__/__

Thank you for completing this form. All information provided is confidential.