**Physical Activity Group Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Surname: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Given names: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Preferred name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender (circle one): | M F |
| Date of birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a message? Yes / No |
| Mobile: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a message? Yes / No |
|  |  |

**Who can we contact, in case of emergency?** (*e.g.: next of kin, case manager, carer, guardian)*

Name of contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Pre Exercise Screening Questionnaire** | **Yes** | **No** |
| 1. Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke |  |  |
| 2. Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise |  |  |
| 3. Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance |  |  |
| 4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months |  |  |
| 5. If you have diabetes (type I or type II) have you had trouble controlling your blood glucose in the last 3 months |  |  |
| 6. Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise |  |  |
| 7. Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise |   |  |

**IF YOU ANSWERED ‘YES’ to any of the 7 questions, please seek guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise**

**An Ambulance will be called should any medical emergency occur to a participant.**

**What/if any is your main health goal for attending our community exercise class**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“I have given to the best of my knowledge an accurate representation of my medical history and agree to inform the Instructor **if any of the above circumstances change in any way** as this may make exercising inappropriate. I accept that there are certain risks involved in any activity and I have had these risks explained."

**Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| **Office Use Only** |  |
| Physiotherapist/Exercise Physiologist Review**Date: Name: Sign:**  |
| **Minimum Data Reviewed**  | Date: Sign: |
| **Copy in Medical Record** | Date: Sign: |