

Name:		Age:		DOB:	
Address:					
Ph:		W:		Mob:	
Email:					
Emergency Contact:		Ph:		Relationship:	
GP Name:		Ph/address:			
Would you like your GP to be updated about your exercise program?				Yes / No	
Do you have, or have ever had, any of the following? (Please circle Yes or No)					
Anyone in your family under 60 who has suffered heart disease, stroke, raised cholesterol or sudden death?					Yes / No
Are you male over 45 or female over 55 and NOT used to regular vigorous exercise?					Yes / No
Are you on prescription medication? (If yes, please specify below)					Yes / No
Have you been hospitalised recently?					Yes / No
Have you given birth in the last 6 weeks?					Yes / No
Are you pregnant?					Yes / No
Do you have any allergies? (If yes, please specify below)					Yes / No
Have you, or do you, suffer from any of the following? (Please circle if Yes or leave blank if No)					
Gout	Yes	Epilepsy	Yes	Hernia	Yes
Stroke	Yes	Diabetes	Yes	Cancer	Yes
Dizziness or fainting	Yes	Glandular fever	Yes	High blood pressure (> 40/90)	Yes
Stomach/duodenal ulcer	Yes	Rheumatic fever	Yes	Raised cholesterol /triglycerides	Yes
Liver/kidney condition	Yes	Osteoporosis/Osteopenia	Yes	Any heart condition (specify below)	Yes
Any other significant medical issue (specify below)					Yes
Please list details of any conditions and medications here (or on back side of form if more space is needed):					
<p>N.B. If you have marked yes to any of the above, please take this form to your doctor prior to exercising, and ask for clearance to exercise, OR sign below if you have already cleared the above condition(s) with your doctor. It is important that you keep us updated if there are any changes to your condition(s) or medications. Your privacy is ensured.</p>					
I hereby agree I have been cleared to exercise, [please sign]				Date cleared:	

Do you have, or have ever had, any of the following? (Please circle Yes or No)					
Osteoarthritis	Yes / No	Please specify treatment & affected areas:			
Rheumatoid Arthritis	Yes / No				
Asthma (note triggers)	Yes / No				
Do you have, or have ever had, pain in the following areas? (Please circle Yes or No)					
Neck	Yes / No	Please elaborate & specify treatment:			
Knees	Yes / No				
Shoulders	Yes / No				
Back	Yes / No				
Ankles	Yes / No				
Any muscular pain	Yes / No				
Are you dieting or fasting?	Yes / No	Do you smoke?	Yes / No	Number a day?	
If you have marked yes to any of the above, please ask the trainer for guidance before starting					
What exercise have you been doing recently?					
How long (mths/yrs):	Duration (mins):	Times a week:	Intensity:	Hard / Medium / Light	
Current blood pressure (taken by staff):		Systolic:		Diastolic:	
Resting heart rate (taken by staff):					
PLEASE READ THE FOLLOWING EXERCISE ADVICE CAREFULLY:					
We are highly qualified and trained exercise professionals. Feel free to ask for guidance on your program &/or any exercises at any time. Work at a low level on your first visit and concentrate on learning to do the exercise properly. Work a little harder each time but limit yourself to being able to talk comfortably. Please inform staff if you suffer illness or injury or condition(s) in the future. IT IS RECOMMENDED by the American College of Sport Medicine that males over 35 and females over 45 should have a medical assessment including an exercise ECG, cholesterol and lipid count.					
PROGRAM: There is no obligation to follow your program every time, you are always free to do your own workout.					
PRIVACY: All information is treated as confidential & will not be distributed to any third parties unless at your request.					
CLIENT STATEMENT: I recognise that Over Forty Fitness is not able to provide me with medical advice, and that this information is used merely as a guide to the limitations of my ability to exercise. I have answered all questions to the best of my ability,					
Client signature:			Date:		
Admin area:					
I permit my photo to be taken and stored, for gym admin uses only			Yes / No		
I would like to receive emails, including the regular eNewsletter:			Yes / No		
Where did you hear about Over Forty Fitness (please circle)?			Internet/word of mouth/brochure/Mosman Daily/doctor/friend's name...../other		
Staff signature:			Date:		