

# BeActive Physio Pre-Exercise REGISTRATION FORM

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Have you ever suffered from or do you have.... (Please tick if yes)**

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Gout     | <input type="checkbox"/> Glandular Fever           | <input type="checkbox"/> Cardiac Condition                |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Respiratory Condition            |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness or Fainting     | <input type="checkbox"/> Raised Cholesterol/Triglycerides |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stomach/Duodenal Ulcer    | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Hernia   | <input type="checkbox"/> Liver or Kidney condition | <input type="checkbox"/> Other _____                      |

Do you smoke? : \_\_\_\_\_  
If yes, how many per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Are you Male over 35 or Female over 45 and unaccustomed to regular exercise?  Yes  No

Has anyone under 60 in your family suffered a stroke, heart disease, raised cholesterol or sudden death?  Yes  No

Have you given birth within the last 6 weeks?  Yes  No

Have you ever had a caesarean birth?  Yes  No

Are you pregnant?  Yes  No

Do you have any infections?  Yes  No

Do you have an infectious disease?  Yes  No

Have you been hospitalised recently?  Yes  No

Are you dieting or fasting?  Yes  No

Are you on any prescribed medications? (If yes, please name)  Yes  No

---

---

---

**PTO**

Do you have any major injuries or muscle or joint pain in the following areas?  
(Please circle)

Neck            Back            Shoulder            Knees            Ankles            Other

If yes to any of above, please provide details

---

---

Are there any other conditions, which may be reason to modify your exercise program?

---

---

Sporting activities performed per week?

---

---

Are you seeing a health practitioner?             Yes     No

If yes, please name: \_\_\_\_\_ Phone: \_\_\_\_\_

What makes your pain worse?

---

---

What relieves your pain?

---

---

**Please read the following exercise advice carefully:**

Please work at a low level on your first visit and concentrate on learning to do the exercise correctly. On each visit you will be able to progressively work harder. Be sure to limit yourself to a pace where you can still TALK comfortably. Please also inform your instructor if you feel discomfort during or within 3 hours of your workout.

Should you suffer any injury or condition in the future, please inform us so we can update this form.

I have read the above and agree to inform the instructor should there be any changes to my condition, before participating in or continuing a class.

I have answered the questions to the best of my ability and understand the advice above, and to the extent permitted by statute hereby waive my right to pursue any claim as a result of my participation in the exercise session to which the application relates.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Guardian (If under 16 years):**

---

**Physiotherapist:** \_\_\_\_\_ **Date:** \_\_\_\_\_