

SCREENING FORM

Instructor: _____

Class: M T W T F S

Time: _____ AM | PM

PLEASE FILL IN THE FOLLOWING DETAILS

NAMES :

DATE OF BIRTH:

ADDRESS: _____

OCCUPATION:

HOME TEL:

POSTCODE: _____

MOBILE TEL:

Where did you hear about us? Please tick ALL applicable:

 Friend Leaflet Poster Advert Web search Facebook

EMAIL:

Please tell us who/where/which advert/what words

Please tick if you are **HAPPY** for us to contact you by:

To receive our eNewsletter and urgent class notices/updates you will need to tick the email box

Post Email Please tick 'NONE' or the relevant box if you answer 'YES' to any of the following: 'NONE'

1. Have you ever been diagnosed with:

- Heart disease?
- High blood pressure?
- Any other cardiovascular problems?
- Diabetes?
- Asthma?
- Epilepsy?

4. Do you have any pain or limited movement in:

- Knee? Lower back?
- Neck? Hip? Other:

8. Are you taking any medication?

 Yes

2. Are you prone to:

- Headaches?
- Fainting?
- Dizziness?

5. Are you or have you been pregnant in the last 3 months?

 Yes

9. Do you have any special needs or any other conditions that may affect your participation in weight management or exercise?

 Yes

3. Have you ever suffered from:

- Accountable chest pain?
- Unaccountable chest pain?

6. Will exercising in class be new to you?

 Yes

7. Do you have any known allergies?

 Yes

Instructors comments:

Assumption of Risk: I hereby state that I have read, understood and answered honestly the questions above. I also state that I wish to participate in activities, which may include aerobic exercise, resistance exercise and stretching. I realise that my participation in these activities involves the risk of injury and even the possibility of death. Furthermore, I hereby confirm that I am voluntarily engaging in an acceptable level of exercise, which has been recommended to me. Should I attend a class led by another instructor I accept responsibility for informing them of, and keeping my instructor updated with any changes to, my medical condition. Additional note: I have taken medical advice and my doctor has agreed that I should exercise.

Member signature:

Date: