ActiveMoves Exercise Assessment & Referral Form

Low impact exercise classes with Jess Nall • **www.activemoves.com.au**
Adamstown Uniting Church • 228 Brunker Rd, Adamstown NSW

First Name		Surname	
Address Suburb		Postcode	
Mobile		Home Phone	
Email			
Emergency Contact Name		Emergency Contact Phone	
Doctors Name		Doctors Phone Number	
Doctors Practice		DOB	
How did you hear of this program?			
Do you give permission for the instructor to include you in group photos for promotional purposes?		YES:	NO:

- I understand that the ActiveMoves leader cannot give me medical advice.
- I will tell the leader immediately if I feel any symptoms OR if my health status should change from that below.
- I will consult my GP if I wish to try to exercise at a different intensity from ActiveMoves.
- I agree to follow the directions of my ActiveMoves Leader in my exercise program & will exercise at my own pace.
- I authorise the ActiveMoves leader and my GP to communicate about my progress in ActiveMoves & understand that they are bound by the privacy act and will only use information pertinent to my exercise program and medical condition as it relates to exercise.

Please tick the appropriate box if you have, ever had, or are on medication for:					
	YES	**NO**		**YES**	**NO**
Heart attack, angina, palpitations, bypass, pacemaker, valves, angioplasty *(please circle if so)*			High cholesterol		
			High blood pressure (Over 140/90)		
Discomfort in the chest at rest or exertion			Dementia		
Stroke			Hernia		
Epilepsy			Liver or Kidney condition		
Diabetes			Glandular Fever		
Asthma *(if yes, please bring your ventolin to class)*			Osteoporosis		
Swollen feet/ankles			Eating Disorder		
Severe vein disorders in the legs or feet, or ulcers			Rheumatic Fever		
Arthritis or major injuries in any joints			Multiple Sclerosis		
Discomfort in the legs at rest or exertion			Cancer		
Have you had surgery in the past year? If yes, what for?					
Have you been hospitalized recently? If yes, what for?					
Do you often feel faint or have spells of dizziness? If yes, please specify:					
Do you have any infections or infectious diseases? If yes, please specify:					
Are you allergic to anything? If yes, please specify:					
Do you suffer any bone/joint/muscle problems? Details if yes: (eg: Back, Neck, Knees, Ankles)					
Is there anything else?					

If you ticked yes to any of the conditions:

- Please take this form to your doctor and ask for a medical clearance prior to starting any exercise program
- **OR** If you already have a recommendation from your GP to exercise please tick here ___ and sign below:

Doctors Signature: _____ Date: ___/___/___

Statement: I recognize that my Fitness Instructor is not able to provide me with medical advice with regard to the health and that the information above is used as a guideline to the limitations of my ability to exercise. I have cleared any current or previous conditions with my doctor and will advise my Fitness Instructor if my circumstances change. I understand in case of emergency, my nominated emergency contact or GP may be contacted for more information and to report the incident.

Clients Signature _____ Date: ___/___/___