

PRE - ACTIVITY QUESTIONNAIRE

This form is used to determine if there is any further information that will be required from your doctor or treating health professional before commencing the Strength for Life program.

Name: _____ DOB: _____

Address: _____

Telephone: _____ Mobile: _____

GP: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Do you have a heart condition? e.g. Angina, cardiovascular disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have musculoskeletal issues? e.g. arthritis, joint or back problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a neurological condition? e.g. stroke, parkinsons, MS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have high or low blood pressure which is not managed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have diabetes which is unstable?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a respiratory condition? e.g. asthma, emphysema, COPD	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you over age 65 and not exercised for a number of years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been diagnosed with osteoporosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been diagnosed with dementia or similar disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have problems with balance which is undiagnosed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

****If you answered YES to one or more of the above questions you will need to consult your Doctor in person to clarify suitability of Strength for Life and anything the instructor needs to be aware of BEFORE commencing the Strength for Life program. A Strength for Life referral form will be supplied.****

If you answered No to all questions above, you may book in for an assessment with the Strength for Life instructor. **If it is the Partner Centre's policy that all clients require a referral form from their treating health professional, this supercedes the previous statement.**

Please note that it is the client's responsibility to accurately answer the questions above. It is also the responsibility of the client to tell the Strength for life Instructor of any changes in health status that differs from those above. It is recommended you inform your treating health professionals of your involvement in SFL.

If you believe you have fully understood the questions above and answered them to the best of your ability, and agree to notify an appropriate staff member should this information change, then please sign below.

Client Signature: _____

Date: _____