PARTICIPANT TO COMPLETE, INSTRUCTOR TO REVIEW

EXERCISE & TRAINING READINESS ASSESSMENT

Strength for Life
Live longer, live stronger

IMPORTANT INFORMATION: This form is used to ensure that we provide every client with the highest level of care. For most people exercise is fun, positive, and an energising pastime which improves health and leads to an enhanced quality of life. However, there are a small number of people who may be at risk when participating in an exercise program. Such risks include falls, sprains, fracture, or damage to components of the heart/ lung system. We would therefore ask that you read, and complete, this form carefully.

PERSONAL DETAILS

Name: _____ DOB: ____/____/____ Gender: ☐ M ☐ F

Address: _____

Contact numbers;

(Home): _____ (Mobile): _____ (Work): _____

Email address: _____ Occupation: _____

Private Health Insurance Fund: _____

EMERGENCY CONTACT DETAILS

Name: _____ Contact number: _____

MEDICAL DETAILS

General Practitioner: _____

Address: _____

Contact numbers: _____ Email address: _____

Where did you hear about the Living Longer Living Stronger™ program? (please tick one box below)

☐ Newspaper ☐ Radio ☐ Website

☐ Other (please specify) _____

Please tick the appropriate box if you have, ever had, or are on medication for;

☐ Heart problems
☐ Discomfort in the chest at rest or exertion
☐ Epilepsy
☐ Asthma, emphysema, bronchitis - other lung problems
☐ Discomfort in the legs at rest or exertion
☐ Arthritis or major injuries in any joints
☐ Severe vein disorders in the legs, or feet, or ulcers
☐ Liver condition
☐ Kidney condition
☐ Rheumatic fever
☐ Cancer
☐ Diabetes
☐ High cholesterol
☐ High blood pressure
☐ Stroke
☐ Hernia
☐ Osteoporosis
☐ Swollen feet/ankles
☐ Glandular fever
☐ Eating disorder
☐ Dizziness/fainting
☐ Other (please specify) _____

CARDIO-PULMONARY SYSTEM

1. Do you have, or have you experienced:

☐ No ☐ Epilepsy ☐ Fainting
☐ Seizures ☐ Dizzy spells ☐ Convulsions

2. Have you ever had pain or pressure, either at rest or during exercise:

☐ no
☐ in the middle of, or on the left side of, the chest
☐ in the neck region
☐ at the left shoulder or down the left arm

3. Do you take any medications for (please specify name):

☐ No
☐ Heart disease: _____ ☐ Diabetes: _____
☐ Cholesterol: _____ ☐ Blood pressure: _____
☐ Asthma, breathing problems: _____

NEURO-MUSCULAR

4. Do you have any impairments of the following? (tick appropriate box)

- ☐ No
- ☐ Vision or hearing
- ☐ Thermal (temperature control)
- ☐ Speech/ language
- ☐ Motor sensory

5. Have you ever experienced a brain or spinal injury? ☐ Yes ☐ No

6. Do you have, or do you experience:

- ☐ No
- ☐ Pressure sores
- ☐ Poor balance / instability
- ☐ Unsteady gait (walking)

7. In the previous 12 months have you experienced:

- ☐ No
- ☐ Concussion
- ☐ Persistent headaches/ nausea
- ☐ Severe cramps
- ☐ Unexplained muscle soreness

8. Have you suffered any nervous system injury?

- ☐ No
- ☐ Lesion of, or damage to, a nerve
- ☐ Numbness, or pins and needles
- ☐ Other (please specify): _____

MUSCULO-SKELETAL

9. Have you experienced any muscular pain in the last six months? ☐ Yes ☐ No
If yes, please specify: _____

10. Have you experienced any joint pain in the last six months? ☐ Yes ☐ No
If yes, please specify: _____

11. Have you broken any bones in the last 12 months? ☐ Yes ☐ No
If yes, please specify: _____

12. Have you had any musculo-skeletal or joint problems requiring treatment or joint replacement? ☐ Yes ☐ No
If yes, please explain: _____
(Please include problem, treatment and treating physician)

13. Do you, or a blood relative, suffer from a musculo-skeletal problem, such as osteoporosis or arthritis? ☐ Yes ☐ No
If yes, please specify: _____

GENERAL HEALTH

14. Do you have any neurological disorder which may require special needs whilst exercising?
Examples may include: Parkinson's, Alzheimers, or Motor Neurone Disease, Multiple Sclerosis, Downs Syndrome, Cerebral Palsy, or Dementia, or short term memory loss.

_____

15. Are you aware of any medical reason/condition which might prevent you from participating in an exercise program? ☐ Yes ☐ No
If yes, please specify: _____

16. Do you have any allergies which may affect your capacity/ ability to exercise? ☐ Yes ☐ No
If yes, please specify: _____

17. Do you have chronic fatigue syndrome? ☐ Yes ☐ No

18. Have you had surgery in the previous 12 months? ☐ Yes ☐ No
If yes, please explain: _____

19. Is there any other medical conditions not covered that you would like us to know about?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____

_____

MEDICATIONS Please list any medication you are taking (including headache pills) and the frequency of use:

NAME OF MEDICATION/DRUG	FREQUENCY OF USE		
	Daily	Weekly	Monthly
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐
6.	☐	☐	☐
7.	☐	☐	☐

Strength for Life™ (SFL) Participants must read the following statements carefully and sign below understanding that ;

- I understand that the SFL™ Instructor cannot give me medical advice.
- I will tell the Instructor immediately if I feel any symptoms or if my health status changes from that above
- I will consult my GP if I wish to try exercise at a different intensity from SFL™.
- I agree to follow the directions of my SFL™ Instructor in my LLLS™ exercise program and will exercise at my own pace.
- I authorise the SFL™ instructor and my GP to communicate about my progress in SFL™ and 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.
- I understand that a copy of my SFL™ forms can be accessed by the SFL™ Project Management Team (at COTA WA Inc) for monitoring and they are bound by the Privacy Act to use this information for statistical purposes only.

I have read and understood the above statements.

Signature (SFL™ Participant): _____ **Date:** _____