## Lifestyle Fitness Exercise & Training Readiness Form

Shire of Donnybrook Balingup 2025-2026



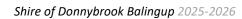
## IMPORTANT INFORMATION:

Due to potential risks associated with exercise, such as falls, sprains, fractures, or cardiopulmonary issues, please read and complete this form carefully.

PERSONAL INFORMATION	
Title: □ Ms □ Mrs □ Mr □	Gender: □ Male □ Female
First name:Last name:	D.O.B
Address:	
Private Health:	
Emergency contact number	
CARDIO PULMONARY SYSTEM.	
☐ In the neck region. ☐ At the left shoul  3: Do you take any medication for:	during exercise? , or on the left side of the chest.
NEURO-MUSCULAR	
4: Do you have any impairments?:  □ No. □ Motor sensory. □ Speech or language.  5: Have you ever experienced a brain or spinal in □ No. □ Yes.  6: Do you have, or ever experienced:  □ No. □ Poor balance. □ Pressure sores. □ Unstantial Trial Tria	teady gait. ced: ausea. □ Severe cramps. □ Unexplained muscle soreness. jury?



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MUSCULO-SKELETAL	
9: Have you experienced any muscular pain in the last six months?  If yes, please specify.	☐ Yes ☐ No
10: Have you experienced any joint pain in the last six months?  If yes, please specify.	□ Yes □ No
11: Have you broken any bones in the last twelve months?  If yes, please specify.	□ Yes □ No
12: Have you had any joint problems requiring treatment or joint replacement?  If yes, please specify.	□ Yes □ No
13: Do you, or a blood relative, suffer from a problem as osteoporosis or arthritis?  If yes, please specify.	□ Yes □ No
GENERAL HEALTH.	
<ul> <li>14: Do you have any neurological disorders that may require special needs while exercising?</li> <li>Examples may include: Parkinson's, Alzheimer's, or motor neuron disease, multiple sclerosis cerebral palsy, and dementia.</li> <li>If yes, please specify.</li> <li>15: Are you aware of any medical reason/condition that might prevent you from participating program?</li> </ul>	s, Down syndrome, ☐ Yes ☐ No
program?  If yes, please specify.  16: Do you have any allergies that may affect your capacity/ability to exercise?	Yes □ No
If yes, please specify	☐ Yes ☐ No☐ Yes ☐ No
19: Do you want us to know any other uncovered medical conditions?  If yes, please specify	☐ Yes ☐ No
MEDICATION.	
Please list any medication you are taking below.  Name of medication.  Daily, Weekly, Monthly.  Purpose of use.  1:	
Please read the statement below and sign that you understand the following  I understand the fitness instructor cannot give medical advice, will follow instructions and e  I authorise the fitness instructort and my GP to communicate about my fitness progress.  I will inform the fitness instructor if I feel any symptoms or if my health status changes from	xercise at my own pace.
Signature participant: Date:	