PRE-EXERCISE ASSESSMENT

This program aims to safely improve fitness, strength, flexibility, balance, and co-ordination.

Venue/Leader details:

PROGRAM PARTICIPANT DETAILS

Full Name: Date of Birth:

Address: Main language spoken at home: ☐ English ☐ Other

Postcode: Participant is: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Phone: Gender: ☐ Male ☐ Female ☐ Other

Email: Participant identifies as: ☐ LGBTQIA+

Where did you hear about *ActiveStrongerBetter?* ☐GP ☐Nurse ☐Health Professional ☐Word of mouth ☐Website ☐Social media

EMERGENCY CONTACT

Name: Phone:

GENERAL PRACTITIONER DETAILS

GP Name: Phone:

Surgery Address:

Please tick if you have ever had, do have, or are you on medication for:

☐	Heart problems (heart attack, angina, palpitations, bypass, pacemaker, valves, angioplasty)	Diabetes	☐
☐	Hernia	Osteoporosis	☐
☐	Stroke	Arthritis or major injuries in the: neck, back, ankles, knees	☐
☐	High blood pressure	Low blood pressure	☐
☐	High cholesterol	Vein disorders in the legs or feet eg large varicose veins, ulcers	☐
☐	Dizziness or fainting	Swollen feet/ankles	☐
☐	Pain or discomfort in the chest when resting or on exertion	Rheumatic Fever	☐
☐	Pains in the legs when resting or on exertion	Eating Disorder	☐
☐	Liver condition	Asthma, emphysema, bronchitis/other lung problems	☐
☐	Kidney condition	Glandular Fever	☐
☐	Are you currently pregnant, trying to fall pregnant or less than 12months postpartum	Epilepsy	☐
☐	Cancer	Multiple Sclerosis	☐
☐	Weight management problems	Other (briefly describe below):	☐
☐	Parkinson's/Huntington's or other neuromuscular illness		

If you ticked yes to any of the above conditions, it is recommended that you see your doctor before exercising (please take this form with you)

OR if you already have medical clearance/advice to exercise: Participant to sign here: Today's Date:

EVERYONE should read the following STATEMENTS carefully and sign below if in AGREEMENT that:

- *I have answered the questions to the best of my ability*
- *I understand that the leader cannot give me medical advice with regard to my medical fitness to exercise*
- *I will tell the leader immediately if my health status should change from above*
- *I agree to follow the directions of my health professional and ActiveStrongerBetter leader with respect to my exercise program*
- *I will work at my own pace, learn the proper technique for the exercises & tell the leader if I feel any symptoms or difficulty relating to exercise*
- *I authorise the leader, my GP and health team to communicate about my progress relating to my exercise program and understand that the leader, GP and health team members 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 have read & understood the above statements. Participant to sign here: Today's Date:

MEDICAL CLEARANCE INFORMATION (To be completed by Health &/or Medical Professional)

Doctor/Health Professional's Name: Email: Phone:

☐ I recommend my client/patient participate in an exercise program suitable for their fitness level and that it relates to their goal for exercise

Goal for exercise:

Stop exercising if:

Optional feedback from the trainer about participation *(please tick)*

☐ Only in the event of problems *(please tick)* ☐ 3 ☐ 6 ☐ 12 monthly Doctor's Signature: Date:

EXERCISE HISTORY

☐ None previous ☐ Maintained regularly Comments:

☐ Recent participation only ☐ Other:

☐ Intermittent

EXERCISE GOALS

Details (date):

PREVIOUS/CURRENT INJURIES

☐ R foot – ankle – knee – hip – femur – tib/fib Comments:

☐ R hand – wrist – elbow -shoulder Limitations:

☐ L foot – ankle – knee – hip – femur – tib/fib Acute / Chronic implications:

☐ L hand – wrist – elbow -shoulder Physical Disabilities / Intellectual Disabilities:

☐ Neck – spine (C T L C) – rib- groin

☐ Muscular: ☐ Other:

HAVE YOU FALLEN IN THE LAST 12 MONTHS

☐ No Comments:

☐ Yes – trip – slip - other

☐ Yes – injured - hospitalised Stepping on? Falls Prevention work:

BALANCE

☐ Good – Unsure – not good Comments:

☐ Mobility Aid / Other: Stepping on?

CONTINENCE

☐ No problem Comments:

☐ Small leakage / Managed Refer to Physiotherapist:

☐ Difficulty / wear pads **Continence Line: 1800 33 00 66**

SMOKER

☐ Never smoked ☐ Current smoker Comments:

☐ Non-smoker but was ☐ Stage of quitting: **Quitline: 137 848**

MENTAL HEALTH HISTORY

☐ None previous Comments:

☐ A carer is required Carer details: (name / phone/email / work for):

☐ Category of Diagnosis:

VISION / HEARING DIFFICULTIES

☐ None previous or current Comments:

☐ Diagnosis – HEARING

☐ Diagnosis - VISION

OTHER

Measurements: **Wt:** kg **Ht:** cm **BMI:** **Waist:** cm

Aged Care Service Provider: **Level of Care / Package:**

Have you seen a Podiatrist recently?

☐ Yes

☐ No

☐ Will do *This can be beneficial prior to starting.*

Get Healthy Coaching Service: 1300 806 258
Free Telephone Support
https://www.gethealthynsw.com.au

Reassessment/Feedback Date: ☐ **Entered in Diary**