

# Pre-Exercise Questionnaire Must be completed and handed in before beginning classes

Please take a few minutes to answer the following questions or work through these with staff. Place a ✓ to indicate "Yes or Not Sure" and a ✗ to indicate "No". The information contained will be treated as confidential and will not be released or revealed without your written consent.

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation/Employer \_\_\_\_\_

Person to be contacted in case of accident: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_

Have you ever had or do you have?

- Anyone in your family under 60 who has suffered Heart Disease, stroke, raised cholesterol or sudden death?
- Are you Male over 35 or Female over 45 and **NOT** used to regular exercise?
- Are you on prescription medication?  Have you been hospitalized recently?
- Have you given birth in the last 6 weeks?  Are you pregnant?

Do you have or have you had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Gout                  | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Palpitations or pain in the chest |
| <input type="checkbox"/> Glandular Fever       | <input type="checkbox"/> Rheumatic fever                   | <input type="checkbox"/> Raised cholesterol/triglycerides  |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> High blood pressure $\geq 140/90$ | <input type="checkbox"/> Hernia                            |
| <input type="checkbox"/> Any Heart Condition   | <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Liver or kidney condition         |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Stomach or duodenal ulcer         | <input type="checkbox"/> Other _____                       |

*If you "✓" any of the above, please take this form to your doctor and ask for a clearance to exercise before starting any exercise program, OR sign below if you have already cleared the above condition with your doctor. Please give details of condition and related medications on the reverse side of this form.*

Condition cleared. Signature \_\_\_\_\_ Date cleared \_\_\_\_\_

Have you ever had or do you have:

- Arthritis  Cramps  Do you smoke?
- Asthma  Are you dieting or fasting

Any pain or major injuries in the following areas?

- Neck  Shoulders  Ankles
- Knees  Back  Any muscular pain?
- Are there any other conditions which may be reason to modify your exercise program? \_\_\_\_\_

*If you "✓" any of the above please ask for exercise class or program guidance before starting*

What exercise have you been doing recently \_\_\_\_\_

Exercise type: \_\_\_\_\_ How long?(mths/years) \_\_\_\_\_ How often? \_\_\_\_\_

Intensity? (circle)      Hard                      Medium                      Light

**PLEASE READ THE FOLLOWING EXERCISE ADVICE CAREFULLY.** Ask teachers to guide you into the most suitable class or program. Work at a low level on your first visit and concentrate on learning to do the exercise properly. On each visit work a little harder but limit yourself to a pace where you can still talk comfortably. Should you suffer any illness, injury or condition in the future, please complete this form again.

**STATEMENT:** I recognize that the instructor is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. I have answered the questions to the best of my ability and understand the advice above.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please Turn Over**

**Wellness Centre Wollongong**

**Instructors Name:** \_\_\_\_\_

**Checked:** \_\_\_\_\_

# ACKNOWLEDGEMENT RELEASE AND ASSUMPTION OF RISK

## Warning

This is an important document, which affects your legal rights and obligations. Please read it carefully and do not sign it unless you understand it. If you have any questions please ask. Password at least 8 characters with 1 or more numbers ( for App)

Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(if under 18 years, parent or guardian to also sign)

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_ Email: \_\_\_\_\_

Password (8) \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

## Acknowledgement of Risks, Injury and Obligations

I acknowledge that the activities I am to undertake have potential dangers and by participating in them I am exposed to certain risks. I acknowledge and understand that whilst participating in any such activities:

- I may be injured, physically, mentally, or may die.
- Any physical conditions I may have, of which I may or may not be aware, of which I may or may not have disclosed to the centre or its staff, may be aggravated or worsened by my participation.
- My personal property may be lost or damaged.
- Other persons participating in such activities may cause me injury or may damage my property.
- I may cause injury to other persons or damage their property.
- The conditions in which activities are conducted may vary without warning.
- I may be injured or die or suffer damage to my property as a result of the negligence or breach of contract of the fitness centre operator, its servants or agents.
- There may be no or inadequate facilities for treatment or transport of me if I am injured.

I assume the risk of, and the responsibility for any injury, illness death or property resulting from my participation in any activities.

## Release and Indemnity to the Fitness Centre Operator

In consideration of the acceptance of my payment (or guest status) for participating in any activity (and except to the extent that the centre may be precluded by statute) I agree to release and indemnify the Wellness Centre Wollongong and staff as follows:

- I participate in the activities at my sole risk and responsibility.
- I release, indemnify and hold harmless the Wellness Centre Wollongong, its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf or by other parties for or in respect of arising out of any injury, loss, damage or death caused to me or my property whether by negligence, breach of contract or in any way whatsoever.
- Class schedule and teachers may be changed without notice.
- We need a minimum of 2 hours notice of class cancellation or a fee may be charged.

I also agree that in the event that I am injured or my property is lost or damaged, I will bring no claim, legal or otherwise, against the Wellness Centre Wollongong or its servants and agents, in respect of that injury, loss or damage.

Before signing this document I have read and understand it and know how it affects my legal rights.

Signed by: \_\_\_\_\_  I have received a copy of WCW Studio Etiquette Date: \_\_\_\_\_

## WHERE PARTICIPANT IS UNDER 18 YEARS OF AGE

I, \_\_\_\_\_ being a parent or legal guardian of the person named in this  
(print name)

Acknowledgement and Release hereby acknowledge and agree:

- I have read the whole document and understand it.
- I consent to the person, named in this Acknowledgement and Release, participating in the activity and
- I am aware of the risks, dangers and obligations set out above in this acknowledgement and release.

In consideration of the person named in this Acknowledgement and Release being accepted to participate in any activity I agree to release and indemnify the Wellness Centre Wollongong, its servants and agents, in the same manner and to the same effect and extent as if I were the person first named in this Acknowledgement and Release and the person participating in any of the activities.

Signature of Parent / Guardian: \_\_\_\_\_  I have received a copy of WCW Studio Etiquette Date: \_\_\_\_\_

Please Turn Over