PRE-EXERCISE ASSESSMENT

Safely improve fitness, strength, flexibility, balance, co-ordination and social interaction. These help to build confidence and independence.

www.activestrongerbetter.net
Class location:

Leader name:

PROGRAM PARTICIPANT DETAILS

Full Name:
Date of Birth:
Postcode:
Phone:
Email:

Main language spoken at home ☐ English ☐ Other: _____

Participant is: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Gender: ☐ Male ☐ Female ☐ Other

How did you hear about ASB: ☐ GP/health professional ☐ Word of mouth ☐ Internet/social media ☐ Other: _____

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*	*Sleep disorder/s*	☐
☐	*Parkinson's/Huntington's or other neuromuscular illness*	*Other (briefly describe here):*	

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

☐ *Non 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? **Get Healthy Coaching Service: 1300 806 258**

☐ *Yes* **Free Telephone Support**

☐ *No* https://www.gethealthynsw.com.au

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

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