Karen Evans
Exercise Physiologist
0418 489 388

# Medical Questionnaire Form

## Client Details

| | | | |
|---|---|---|---|
| Client Name: | | DOB: | |
| Address: | | | |
| Email: | | Mobile: | |
| Emergency Contact: | | Phone: | |

## Medical History and Disclosure

Circle Response

| | | | |
|---|---|---|---|
| 1. | Are you over 35 years of age and NOT used to regular exercise? | Yes | No |
| 2. | Have you or anyone in your immediate family under 55 years old, suffered / suffering a heart condition, stroke, raised blood pressure, raised cholesterol, sudden death? | Yes | No |
| 3. | Have you been hospitalized in the last 5 years? | Yes | No |
| 4. | Are you pregnant or have you given birth in the last 6 weeks? | Yes | No |
| 5. | Do you have any infection / infectious disease? If YES, specify. | Yes | No |
| 6. | Are you on any medication? If YES, specify. | Yes | No |
| 7. | Do you have /or had any of the following conditions:<br>• Diabetes<br>• Epilepsy<br>• Hernia<br>• Asthma<br>• Liver / Kidney condition | <br>Yes<br>Yes<br>Yes<br>Yes<br>Yes | <br>No<br>No<br>No<br>No<br>No |
| 8. | Is there any injury / condition that may hinder / limit you during exercise? If YES, specify. | Yes | No |
| 9. | Are you a smoker? If YES, how many per day? | Yes | No |
| 10. | Are you dieting or fasting? | Yes | No |
| 11. | Do you currently exercise vigorously 3 or more times a week? | Yes | No |

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## Session Cancellation Policy

- I understand that commitment is part of my training and accept that a 50% session fee will apply for a cancellation less than 24 hours within a minimum of 12 hours' notice; and full session fee will apply for a cancellation less than 12 hours prior to the scheduled appointment time.
- Clients may reschedule or cancel an appointment with a minimum of 24 hours' notice at no charge.

## Client Acknowledgement

- I realise that participation in exercise carries some risk.
- I understand all the questions on this form and have answered them truthfully.
- I hereby certify that I am aware of no medical condition (except those already noted) that may increase my risk of illness or injury as a result of my participation in a regular exercise program.
- I have read and understood this questionnaire and accept all risks associated with the undertaking of a fitness program and hereby exempt, release and discharge Health Smart and its employees, contractors, sub-contractors or any associate companies for any injury, illness or adverse change in my medical condition or state of health arising directly or indirectly from any current or future training, instruction, rehabilitation or exercise program recommended by or undertaken with Health Smart and/or its employees, contractors, subcontractors or any associate companies.

## Client Signature

Client Signature: _____✗ Date: _____/_____/_____

Client Name: _____