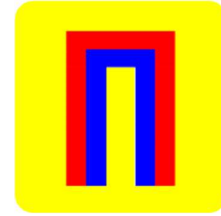


# EXERCISE CONSENT FORM

PHYSIQ.COM.AU

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Name

Birthdate

Address

Phone

Email

Occupation

How did you find us?

What do you want?

What is your background or experience in physical activity?

Do you have any injury, trauma or a diagnosed medical condition? YES / NO  
If yes, please state

Do you experience any pain day or night? YES / NO

Do you have pain right now? YES / NO

Where is your pain when you feel it?

How do you fix your pain?

When did your pain start?

What causes your pain?

Have you been hospitalised, had any scans or procedures in the last three years? YES / NO  
What were they?

Are you allergic? YES / NO

What are you allergic to?

Do you have asthma? YES / NO

Is your asthma controlled? YES / NO

Is your sleep restful? YES / NO

Do you have heart condition? YES / NO

Have you ever experienced pain in the chest? YES / NO

Do you have swollen ankles? YES / NO

Have you ever felt dizzy? YES / NO

Have you ever lost consciousness or fainted? YES / NO

Are you on blood thinners? YES / NO

Have you been diagnosed with a dizziness disorder? YES / NO

What was the date (approximately) of your last fall?

What was the cause of your last fall?

Do you have high blood pressure a.k.a hypertension? YES / NO

Do you have high cholesterol? YES / NO

Do you have diabetes? YES, TYPE I / YES, TYPE II / NO

Do you have high blood sugar? YES / NO

If you monitor your blood sugar, what is your typical blood sugar reading?

Are you on any medication? YES / NO

What is your medication and dosage?

Do you have a regular Specialist, Doctor or Health Professional? YES / NO

What type of Doctor or Specialist are they?

Are you pregnant or perinatal? NEITHER / PREGNANT / PERINATAL

Emergency contact name and their relation to you

Emergency contact number

Is there anything else you want to express? YES / NO

What is it?

This is true and correct to the best of my knowledge

SIGNATURE

DATE

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