

## EXERCISE CONSENT FORM

### Details

1	Name
2	Birthdate
3	Address
4	Phone
5	Email
6	Occupation
7	Education
8	What motivates you?
9	Why are you motivated to fix it now?
10	How did you find us?
11	What do you want?
12	What is your background in physical activity?
13	What is your philosophy on health?
14	Are you ready to be in your best health?
15	Who are your three favourite songs/ artists?
16	

### Health

17	Any ongoing health concerns?	Yes / No
18	What are they?	
19	Do you have any injury, trauma or a diagnosed medical condition?	Yes / No
20	If yes, please state	
21	Have you had any scans, procedures or been hospitalised in the last 3 yrs?	Yes / No
22	Please describe	
23	Do you see any Specialist, Doctor or Health Professional regularly?	Yes / No
24	What type of Doctor or Specialist are they?	
25	How often do you go?	
26	Women only: are you pregnant or perinatal?	Yes / No
27	Are you allergic? What are you allergic to?	Yes / No
28	Do you have asthma?	Yes / No
29	Is your sleep restful?	Yes / No
30	Do you have heart condition?	Yes / No
31	Have you ever experienced pain in the chest?	Yes / No
32	Do you get swollen ankles?	Yes / No
33	Do you have high cholesterol?	Yes / No
34	Do you have diabetes? Type I, Type II or prediabetic	Yes / No
35	Do you have high blood sugar?	Yes / No
36	If you monitor your blood sugar, what is your typical blood sugar reading?	
37	Are you on blood thinners?	Yes / No



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### Medications

38	Please list your medications?	Dosage

### Pain

39	Do you experience any pain day or night?								Yes / No
	Do you have pain right now?								Yes / No
	Where is the pain when you feel it?								Yes / No
	How do you fix it?								Yes / No
	When did it start?								Yes / No
	What causes it?								Yes / No
40	If you have pain, please circle how you would describe the pain								
	flicker	quiver	pulse	beat	pound	jump	flash	shoot	
	prick	boring	drill	stab	lacerate	sharp	cut	lacerate	
	pinch	press	gnaw	cramp	crush	tug	pull	wrench	
	hot	burn	scald	sear	tingle	itch	smart	sting	
	dull	Sore	hurt	ache	heavy	tender	taut	rasp	
	split	tired	exhaust	sick	suffocate	fear	fright	terrify	
	punish	gruel	cruel	vicious	kill	wretch	blind	annoy	
	trouble	misery	intense	unbearable	spread	radiate	penetrate	pierce	
	tight	numb	draw	squeeze	tear	cool	cold	freeze	

### Balance

41	Have you ever lost consciousness or fainted?								Yes / No
42	Have you ever felt dizzy or experienced double vision?								Yes / No
43	Have you been diagnosed with a dizziness disorder?								Yes / No
44	Please describe								
45	Have you had any fallen or had any physical accidents/scares?								Yes / No
46	How did you fall?								
47	How did it happen?								
48	How recent was that?								
49	Do you have high blood pressure/hypertension?								Yes / No
50	Circle the things you physically want more confidence in interacting with								
	Cleaning		dressing		meals		bathing		
	Stairs		walking		rushing		chair	reaching	
	Slippery surfaces		Uneven surfaces		slope		heights		
	Visiting		crowds		friends		shopping		

### Consent

51	In case of an emergency
52	Emergency contact name
53	Emergency contact relation to you
54	Emergency contact number

Walk in with health concerns, walk out without them.

Intelligent Physiq

Tuesday, 27 April 2021



## EXERCISE CONSENT FORM

55	Would you consider your image being used in marketing literature?	Yes / No
56	Feel free to share anything you wish here	
57	This is true and correct to the best of my knowledge	
	Signature	Date

Resource. The Falls-Efficacy Scale International (FES-I).

