**Name**:

**Date of Birth**:

**Phone number**:

**Email address**:

**Emergency contact details** (if you wish to provide these):

**Is there anything you would like support with during the sessions (such as a specific exercise, addressing an issue such as strength or balance, exercise to support a daily activity or hobby)?**

**Is there anything you would like to tell us about yourself that relates to your participation?**

**Pre-Activity Medical Questionnaire**

*If you are unsure about anything, please consult the fitness instructor. All information provided will be treated in confidence. You may be asked to consult your doctor before exercising. However, you may complete an induction before having done so.*

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| **1. How would you describe your present level of activity?**  Highly Inactive ☐ Active ☐  Inactive ☐ Highly Active ☐  Neither Active nor Inactive ☐ | **2. How would you describe your present level of fitness?**  Highly Unfit ☐ Fit ☐  Unfit ☐ Highly Fit ☐  Neither Fit nor Unfit ☐ |
| **3. How would you describe your present weight?**  Highly Underweight ☐ Overweight ☐  Underweight ☐ Highly Overweight ☐  Ideal Weight ☐ | **4a. Do you smoke?**  Yes ☐ *If yes, proceed to question 4c.*  No ☐ |
| **4b. Have you ever smoked?**  Yes ☐  No ☐ *If no, proceed to question 5.* | **4c. How many cigarettes do you (or did you) smoke per day?**  Up to 10 ☐ 21 to 30 ☐  11 to 20 ☐ More than 30 ☐ |
| **5. How would you describe your level of alcohol consumption?**  Drink Daily ☐ Drink Occasionally ☐  Drink Often ☐ Never Drink ☐ | **6. Have you had to consult a doctor in the last six months?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 7.*  …………………………………………………………………… |
| **7a. Are you presently taking any form of medication?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 8.*  ……………………………………………………………………  ……………………………………………………………………  …………………………………………………………………… | **7b. Do any of these medications have side effects have any implications on physical activity?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 8.*  *……………………………………………………………………*  …………………………………………………………………… |
| **8. Do you or have you ever suffered from any of the following?**  Arthritis ☐ Diabetes ☐  Asthma ☐ Epilepsy ☐  Bronchitis ☐  Heart Disease (including heart attack or failure) ☐  Bone density conditions ☐  Any heart or circulatory conditions ☐  Loss of Balance / Dizziness ☐  Chest pain during exertion or rest ☐  Very fast. very slow or irregular heartbeats ☐  High blood pressure ☐  Low blood pressure ☐  Shortness of breath at any time ☐  Fracture in the spine, hip or wrist ☐  *If you suffer / have ever suffered from any of the above, provide details below.*  …………………………………………………………………… | **9. Is there a history of heart disease in your family?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 10.*  …………………………………………………………………… |

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| **10. Do you currently have any form of muscle or joint injury?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 11.*  …………………………………………………………………… | **11. Do you consider yourself to have a disability?**  Yes ☐ *If yes, provide details below*  No ☐ *If no, proceed to question 12.*  …………………………………………………………………… |
| **12. Have you ever had surgery? No, please continue to question 13.**  Heart surgery (if yes please provide details) ☐  Pacemaker/implantable cardiac defibrillator ☐  Joint replacement of (please insert name) ☐  Coronary angioplasty ☐  Organ transplant (please provide details) ☐  Other joint/muscle surgery (please provide details) ☐  Appendectomy ☐  Other (please provide details) ☐  Details (date / cleared by surgeon / any impact on physical activity):  ……………………………………………………………………….  ……………………………………………………………………….  ……………………………………………………………………….. | **13. Do you have a diagnosed memory condition?**  Yes ☐ *If yes, provide details below.*  No ☐ *If no, proceed to question 14.*  …………………………………………………………………… |
| **14. Have you fallen 2 or more times in the last 12 months, no matter the cause/reason?**  Yes ☐  No ☐  If yes please provide details:  ………………………………………………………………………  ………………………………………………………………………  ………………………………………………………………………. | **15. Have you ever been told not to exercise by a GP?**  Yes ☐  No ☐ |
| **16. Have you had COVID-19?**  Yes ☐  No ☐ | **17. If Yes to Q16, what treatment did you receive?**  ……………………………………………………………………  ……………………………………………………………………  …………………………………………………………………… |
| **18. Do you currently have Long COVID?**  Yes ☐  No ☐ | **19. If you have Long COVID, what treatment are you currently receiving?**  ……………………………………………………………………  ……………………………………………………………………  …………………………………………………………………… |

**Informed Consent**

* Certain risks of injury are inherent to participation in exercise; these types of injuries may be minor or serious and may result from my own actions and / or those of others.
* I understand that I should be well enough to participate and that the choice to participate brings with it the assumption of those risks and results which are part of the activity.
* The rules, regulations and terms and conditions of the YSJActive Health Gym are designed for the safety and protection of participants and I agree to abide by these (these are available on the booking system).
* I agree that I will not attempt or carry out Olympic lifts (i.e. clean / snatch) or equivalent if I am not trained and competent in doing so.
* Anyone thought to be under the influence of alcohol or drugs will be ejected. I agree not to attend if I am, or believe I may, be under the influence of alcohol or drugs.
* Personal belongings left in changing rooms or lockers are at the owner’s risk and the university accepts no liability for theft or damage to such belongings. Please use a locker or pigeon hole and do not have bags or coats on the floor of the gym.
* Any photography will only be done with consent and you will be asked to sign a photography consent form.
* I agree that I will inform staff if my medical status changes.
* I agree that I will not attend a class or the gym if I am unwell.

By signing this declaration, I agree that I have read and understood the above statements and that my medical information is correct. Any questions I had were answered to my full satisfaction.

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| Name of participant (printed):  Signature of participant:  Date: | Name of instructor (printed):  Signature of instructor:  Date: |
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