

## PRE - ACTIVITY QUESTIONNAIRE

*This form is used to determine if there is any further information that will be required from your doctor or treating health professional before commencing the Strength for Life (SFL) program.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 GP: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**\*\* It is recommended that all participants intending to participate in SFL sessions visit their Doctor beforehand, so that their ongoing health can be managed appropriately.\*\***

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you have a heart condition? e.g. Angina, cardiovascular disease     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a neurological condition? e.g. stroke, parkinsons, MS, MND | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have high or low blood pressure which is not managed?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have diabetes which is unstable?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a respiratory condition? e.g. asthma, emphysema, COPD      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you over age 65 and been completely inactive for the last 2 years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you ever had cancer requiring chemotherapy or radiotherapy?       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**\*\*If you answered YES to one or more of the above questions you will need to consult your Doctor in person for a referral to Strength for Life\*\* (Medical referral form)**

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Do you or have you ever suffered from back problems requiring treatment?    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have knee or hip problems that require ongoing attention?            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have arthritis which requires health professional assistance?        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you being treated for osteoporosis? <b>Bone Density report required</b> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**\*\*If you answered YES to one or more of the questions, directly above, you will need to consult your allied health professional (physio or exercise physiologist) instead of your Doctor, in person for a referral to SFL\*\* (Allied Health Referral form)**

**\*\*These referral forms are available from the website, SFL provider or your medical or allied health professional\*\***

**If you answered No to all questions above, you may book in for an assessment with the SFL instructor. \*\*If it is the Partner Centre's policy that all clients require a referral form from their treating health professional, this supercedes the previous statement.\*\***

Please note that it is the client's responsibility to accurately answer the questions above. It is also the responsibility of the client to tell the Strength for life Instructor of any changes in health status that differs from those above. It is recommended you inform your treating health professionals of your involvement in SFL.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_