



# Group Exercise Registration Form

Please hand this form to the Exercise Physiologist before your first session.

	dd / mm / year
<b>Name</b>	<b>Date of Birth</b>

Are you able to exercise independently within a group setting?  Yes  No

To the best of your knowledge, is it safe for you to exercise and are your current health conditions well managed?  Yes  No

If you answered no to any of the above, GP clearance to exercise may be required or a private 1:1 exercise physiology consultation may be more appropriate for you.

By attending this exercise group, you consent to the following:

- I understand this is a group exercise session run at **Xistance gym Daylesford**, delivered by Springs Medical Exercise Physiologist.
- I understand will be supervised during the session, but I am responsible for my own health and safety and will work within my own limitations and capacity.
- I will speak to the Exercise Physiologist running the group if I am struggling, experiencing pain or discomfort or are unsure about any exercise.

Are you a current patient at Springs Medical?  Yes  No If not, please complete medical history below.

## Medical History

	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide further details:
Any known current medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any unexplained chest pain or shortness of breath? (i.e., not due to exercise or physical exertion)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any history of fainting, feeling dizzy or lightheaded?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any balance issues? -any falls or near misses in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any blood pressure issues? -do you take medication to control blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have Asthma? --do you have a puffer and/or asthma action plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have Diabetes? - type 1 or type 2?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any muscle/bone/joint issues? (i.e., arthritis, joint replacement etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
To your knowledge is there anything else impacting your ability to exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Emergency Contact</b>			
	<b>Name</b>	<b>Relationship</b>	<b>Contact number</b>

	dd / mm / year
<b>Signature</b>	<b>Date</b>

● **10 Hospital Street  
Daylesford 3460**  
t: 03 5348 2227  
f: 03 5348 1447

● **22 Victoria Street  
Trentham 3458**  
t: 03 5424 1602  
f: 03 5424 1851

● **89 Piper Street  
Kyneton 3444**  
t: 03 5422 1298  
f: 03 5422 1307