|  |  |
| --- | --- |
| Surname: | First Name: |
| Title: | Date of Birth: |
| Address: | |
| Suburb/State: | Post Code: |
| Email: | Occupation: |
| Home Phone: | Mobile: |
| Emergency Contact: | Name and Relationship: |

Please tick the Category you are participating.

□ Tai Chi classes □ Martial Art Fitness classes\*\* □ Personal Training □ Workshop & Events

**Pre-exercise Assessment – Please read carefully and tick the relevant boxes:**

1. Has the Doctor ever told you that you have a heart condition or have you ever suffered a stroke?

□ Yes □ No

1. Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?

□ Yes □ No

1. Do you ever feel faint or have spells of dizziness during physical activity that causes you to lose balance?

□ Yes □ No

1. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?

□ Yes □ No

1. If you have diabetes (type I or II) have you had trouble controlling your blood glucose in the last 3 months?

□ Yes □ No

1. Do you have any diagnosed muscle, bone or joint problems that you have told could be made worse by participating in physical activity/exercise?

□ Yes □ No

1. Do you have any other medical condition that may make it dangerous for you to participate in Physical exercise?

□ Yes □ No

If you have answered ‘Yes’ to any of the 7 questions and/or participating in the Martial Art Fitness Class\*\*, a formal letter of clearance will need to be signed by your GP or Allied health professional and passed on to Vo Dao TCF prior to undertaking physical activity/exercise.

If you have answered ‘No’ to all of the 7 questions and you have no other concerns about your health, you may proceed to undertake light moderate intensity physical activity.

**Tick any of the following problems you have experienced:**

□ Low/Mid back pain

□ Neck/Shoulder pain

□ Digestive problems

□ Sleeping problems

□ Ringing in ears

□ Headach/Migraine

□ Menstrual pain

□ Chest pain

□ Allergies

□ Asthma/Sinus

□ Tiredness/Fatigue

□ Acne/Eczema

**Which problem above is the worst?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **And How long have you had this problem?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Does this cause you to be?** | **Does this affect your work?** | **Does this affect your life?** |
| Depressed  Irritable  Sleepless  Restricted in daily activities  Uncomfortable sitting and standing | Making decisions  Attitude towards work  Lowering your productivity  Reducing hours you can work  Exhausts you by the end of the day | Emotional  Headache  Forgetful  Limits your social life  Poor memory |

If you tick any of the above questions, Are you suffering from either of the following If so please tick below.

□ Stressed □ Pinched nerves □ Structural Alignment □ Hypertension □ High Blood Sugar □ High Cholesterol

I declare that I have answered this enrolment form and pre-exercise assessment accurately and honestly in declaring my fitness, health and medical conditions to the Vo Dao TCF instructor in order to participate in the physical activities that are to be undertaken.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_