

# EXERCISE & TRAINING READINESS ASSESSMENT



IMPORTANT INFORMATION: This form is used to ensure that we provide every client with the highest level of care. For most people exercise is fun, positive, and an energising pastime which improves health and leads to an enhanced quality of life. However, there are a small number of people who may be at risk when participating in an exercise program. Such risks include falls, sprains, fracture, or damage to components of the heart/lung system. We would therefore ask that you read, and complete, this form carefully.

## PERSONAL DETAILS

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F  
Address: \_\_\_\_\_  
Contact numbers;  
(Home): \_\_\_\_\_ (Mobile): \_\_\_\_\_ (Work): \_\_\_\_\_  
Email address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Private Health Insurance Fund: \_\_\_\_\_

## EMERGENCY CONTACT DETAILS

Name: \_\_\_\_\_ Contact number: \_\_\_\_\_

## MEDICAL DETAILS

General Practitioner: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact numbers: \_\_\_\_\_ Email address: \_\_\_\_\_

Where did you hear about the Living Longer Living Stronger™ program? (please tick one box below)

- Newspaper  Radio  Website  
 Other (please specify) \_\_\_\_\_

Please tick the appropriate box if you have, ever had, or are on medication for;

- |  |  |
|--|--|
| <input type="checkbox"/> Heart problems  | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Discomfort in the chest at rest or exertion           | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma, emphysema, bronchitis - other lung problems   | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Discomfort in the legs at rest or exertion            | <input type="checkbox"/> Hernia              |
| <input type="checkbox"/> Arthritis or major injuries in any joints             | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Severe vein disorders in the legs, or feet, or ulcers | <input type="checkbox"/> Swollen feet/ankles |
| <input type="checkbox"/> Liver condition                                       | <input type="checkbox"/> Glandular fever     |
| <input type="checkbox"/> Kidney condition                                      | <input type="checkbox"/> Eating disorder     |
| <input type="checkbox"/> Rheumatic fever                                       | <input type="checkbox"/> Dizziness/fainting  |
| <input type="checkbox"/> Cancer  |  |
| <input type="checkbox"/> Other (please specify) _____                          |  |

## CARDIO-PULMONARY SYSTEM

1. Do you have, or have you experienced:

- No  Epilepsy  Fainting  
 Seizures  Dizzy spells  Convulsions

2. Have you ever had pain or pressure, either at rest or during exercise:

- no  
 in the middle of, or on the left side of, the chest  
 in the neck region  
 at the left shoulder or down the left arm

3. Do you take any medications for (please specify name):

- No  
 Heart disease: \_\_\_\_\_  Diabetes: \_\_\_\_\_  
 Cholesterol: \_\_\_\_\_  Blood pressure: \_\_\_\_\_  
 Asthma, breathing problems: \_\_\_\_\_

## NEURO-MUSCULAR

4. Do you have any impairments of the following? (tick appropriate box)

- No  Vision or hearing  
 Thermal (temperature control)  Speech/ language  
 Motor sensory

5. Have you ever experienced a brain or spinal injury?  Yes  No

6. Do you have, or do you experience:

- No  Pressure sores  
 Poor balance / instability  Unsteady gait (walking)

7. In the previous 12 months have you experienced:

- No  Concussion  Persistent headaches/ nausea  
 Severe cramps  Unexplained muscle soreness

8. Have you suffered any nervous system injury?

- No  
 Lesion of, or damage to, a nerve  
 Numbness, or pins and needles  
 Other (please specify): \_\_\_\_\_

## MUSCULO-SKELETAL

9. Have you experienced any muscular pain in the last six months?  Yes  No

If yes, please specify: \_\_\_\_\_

10. Have you experienced any joint pain in the last six months?  Yes  No

If yes, please specify: \_\_\_\_\_

11. Have you broken any bones in the last 12 months?  Yes  No

If yes, please specify: \_\_\_\_\_

12. Have you had any musculo-skeletal or joint problems requiring treatment or joint replacement?  Yes  No

If yes, please explain: \_\_\_\_\_  
(Please include problem, treatment and treating physician)

13. Do you, or a blood relative, suffer from a musculo-skeletal problem, such as osteoporosis or arthritis?  Yes  No

If yes, please specify: \_\_\_\_\_

## GENERAL HEALTH

14. Do you have any neurological disorder which may require special needs whilst exercising?

Examples may include: Parkinson's, Alzheimers, or Motor Neurone Disease, Multiple Sclerosis, Downs Syndrome, Cerebral Palsy, or Dementia, or short term memory loss.

15. Are you aware of any medical reason/condition which might prevent you from participating in an exercise program?  Yes  No

If yes, please specify: \_\_\_\_\_

16. Do you have any allergies which may affect your capacity/ ability to exercise?  Yes  No

If yes, please specify: \_\_\_\_\_

17. Do you have chronic fatigue syndrome?  Yes  No

18. Have you had surgery in the previous 12 months?  Yes  No

If yes, please explain: \_\_\_\_\_

19. Is there any other medical conditions not covered that you would like us to know about?

Yes

No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

Please list any medication you are taking (including headache pills) and the frequency of use:

NAME OF MEDICATION/DRUG	FREQUENCY OF USE		
	Daily	Weekly	Monthly
1.			
2.			
3.			
4.			
5.			
6.			
7.			

**Living Longer Living Stronger™ (LLLS) participants must read the following statements carefully and sign below understanding that;**

- I understand that the LLLS™ instructor cannot give me medical advice.
- I will tell the leader immediately if I feel any symptoms or if my health status changes from that above
- I will consult my GP if I wish to try exercise at a different intensity from LLLS™.
- I agree to follow the directions of my LLLS™ instructor in my LLLS™ exercise program and will exercise at my own pace.
- I authorise the LLLS™ instructor and my GP to communicate about my progress in LLLS™ and understand that they are bound by the privacy act and will only use information pertinent to my exercise program and medical condition as it relates to exercise.
- I understand that a copy of this form goes to the LLLS™ Project Management Team (at COTA WA Inc) for monitoring and they are bound by the privacy act to use this information for statistical purposes only.

**I have read and understood the above statements.**

**Signature (LLLS™ Participant):** \_\_\_\_\_ **Date:** \_\_\_\_\_

