**REBOOT Program Client Details & Clearance Form**

The information obtained will be treated as confidential and will not be released or revealed to any person without your written consent. The information obtained may be used for statistical or scientific purpose with your right of privacy retained.

How did you hear about the REBOOT program?

🞎 Internet search 🞎 Social media 🞎 Word of mouth 🞎 GP/Specialist 🞎 Other

**PERSONAL INFORMATION**

Name: Age: DOB: \_ \_/ \_/\_ \_\_\_

Address:

Phone: Email:

Occupation:

**EMERGENCY CONTACT**

Name: Relationship:

Phone: Email:

**CURRENT MEDICATIONS/SUPPLEMENTS**

Please list any medications or supplements you are currently taking or prescribed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT OR PRE-EXISTING CONDITIONS OR INJURIES**

If you have experienced any conditions/injuries that impact your ability to exercise please specify below:

**HEALTH & FITNESS GOALS FOR REBOOT**

What are your 3 health and fitness goals and objectives for this program?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ESSA PRE-EXERCISE & CURRENT HEALTH SCREENING**

**Have you ever had or do you currently have any of the conditions below?**

|  |  |  |
| --- | --- | --- |
| * Has your doctor said you have a heart condition or have you suffered a stroke?

If yes, please specify: | Yes | No |
| * Do you have a family history of heart condition or stroke?

If yes, please specify: | Yes | No |
| * High blood pressure
 | Yes | No |
| * High cholesterol or triglycerides
 | Yes | No |
| * Are you a smoker?
 | Yes | No |
| * Do you experience unexplained chest pain at rest or during physical activity?
 | Yes | No |
| * Do you feel faint or have dizziness during physical activity that causes loss of balance?
 | Yes | No |
| * Have you experienced a fall in the last 12 months

If yes, please specify: | Yes | No |
| * Do you experience breathing difficulties or have you had an asthma attack requiring medical attention over the last 12 months?
 | Yes | No |
| * Do you have type 1 or type 2 diabetes

If yes, have you had trouble controlling your glucose levels in the last 3 months? Yes / No  | Yes | No |
| * Do you have a diagnosed muscle, bone or joint problems that may worsen when participating in physical activity?

If yes, please specify: | Yes | No |
| * Arthritis (Osteoarthritis/Rheumatoid)
 | Yes | No |
| * Back pain/discomfort
 | Yes | No |
| * Muscular/Joint/Ligament/Tendon injury

If yes, please specify: | Yes | No |
| * Chronic pain
 | Yes | No |
| * Mental illness

If yes, please specify: | Yes | No |
| * Cancer

If yes, please specify current treatment circumstances: | Yes | No |
| * Rheumatic fever
 | Yes | No |
| * Gout
 | Yes | No |
| * Stomach/Duodenal ulcer
 | Yes | No |
| * Hernia
 | Yes | No |
| * Liver/Kidney condition or disease
 | Yes | No |
| * Epilepsy
 | Yes | No |
| * Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity?

If yes, please specify: | Yes | No |

CLEARANCE FORM

RISK WARNING ACKNOWLEDGMENT AND ASSUMPTION OF RISK RELEASE & INDEMNITY

WARNING: THIS IS AN IMPORTANT DOCUMENT WHICH AFFECTS YOUR LEGAL RIGHTS AND OBLIGATIONS. READ IT CAREFULLY AND DO NOT SIGN IT UNLESS YOU ARE SATISFIED THAT YOU UNDERSTAND IT. IF YOU HAVE ANY QUESTIONS PLEASE ASK OUR REPRESENTATIVE.

RECREATIONAL ACTIVITY PROVIDER: ELITE HEALTH MANAGEMENT TRADING AS THE EXERCISE THERAPIST

**Participants Name:** Age:

**\*\***(If under 18 years, parent/guardian to also sign)

## WARNING AND ACKNOWLEDGMENT OF RISKS, INJURY AND OBLIGATIONS

I Acknowledge that the activity I am to undertake is a dangerous recreational activity that may involve a significant risk of physical harm (the “activity”) and that by participating in it I am exposed to certain risks. **I further acknowledge that I am not required to engage in the activity.**

**RELEASE AND INDEMNITY TO THE RECREATIONAL ACTIVITY PROVIDER**

**In Consideration** of my payment for participating in the activity (and except to the extent that the same may be precluded by statute) **I Agree to Release and** I**ndemnify** the Recreational Activity Provider as follows:

1. I participate in the activity at my own risk and responsibility.
2. I release, indemnify and hold harmless the Recreational Activity Provider, its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf or by other parties for or in respect of or arising out of any injury, loss, damage or death caused to me or my property in any way whatsoever or any liability that results from the breach of an express or implied warranty that the recreational services or activity will be rendered with reasonable care or skill.

**BEFORE SIGNING THIS DOCUMENT:**

* **I have read and understood it and know that it affects my legal rights**
* **The above represents and warrants to Elite Health Management PTY LTD (trading as The Exercise Therapist) that I have disclosed all details or any medical condition I have and of all recent medical treatment received by me**
* **I have read and understood all Terms and Conditions. We do not provide refunds on Thrive Clinic programs or The Exercise Therapist services (this includes private consultations and group training programs), however, will allow discussion and review of specific circumstances with Director of The Exercise Therapist, Katie Stewart.**

Appointment reminders are sent one day prior, please tick preferred option: 🞎 SMS 🞎 Email

I would like to receive important clinic communications, research articles and promotions via email 🞎 Yes 🞎 No

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign: Date:

AEP Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign: Date: