

CONTACT - PH. 0412 992 554

www.plusonefitness.com.au

59 Eltham St, Gladesville, 2111

REGISTRATION & HEALTH QUESTIONARE

PERSONAL DETAILS

NAME:……………………………………………………………………………………………...……

DOB: ……………………………………………AGE:…………………………………………………..

ADDRESS:….....…………………………………………………………………………………………..

PHONE:(H)………………………(M)……………………………

Emergency Contact………........………...………....PHONE:.............................................................

EMAIL:…………………………………………………………………………………………………..

MEDICAL CONDITIONS? (Please Circle)

|  |  |  |  |
| --- | --- | --- | --- |
| Smoker  | Y/N | Low or reduced bone density  | Y/N |
| Asthma  | Y/N | Arthritis | Y/N |
| Diabetes  | Y/N | Acute joint injury | Y/N |
| Epilepsy  | Y/N | Chronic joint injury  | Y/N |
| Allergies  | Y/N | Acute muscular injury  | Y/N |
| Any Heart conditions | Y/N | Chronic muscular injury  | Y/N |
| Any Respiratory conditions | Y/N | Recovering from any recent surgery | Y/N |
| Any Circulatory/Blood conditions  | Y/N |  |  |
| Chronic high blood pressure | Y/N |  |  |

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE PROVIDE FURTHER DETAILS

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……………………………………………………………………………………………………………

MEDICATIONS EG ASTHMA .DIABETES, DEPRESSION

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

PAST INJURIES-MUSCULOSKELETAL (BACK/PELVIC PAIN ETC…)

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……………………………………………………………………………………………………………

PREVIOUS TREATMENT PHYSIOTHERAPY/CHIROPRACTOR/OSTEIOPATH/

SURGERY {YEAR)

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

ARE YOU PREGNANT?:…..…...

ESTIMATED DATE OF DELIVERY:…………………………………………

OBSTETRICAN…………….....………………………...………CONTACT NO………………...………

GENERALPRACTITIONER…………………......………..…….CONTACT NO………....……………...

DOCTORS LETTER ATTACHED?................................................

POSTNATAL…......…….

NUMBER OF .CHILDREN……………………………………………………

TYPE OF DELIVERY- VAGINAL/CAESARIAN

1.NAME……………....................AGE:…..… TYPE OF DELIVERY………………………………….

2.NAME……………...................AGE:………TYPE OF DELIVERY………………………………….

3.NAME……………...................AGE:..…… TYPE OF DELIVERY…………………………………..

ANY PELVIC FLOOR PROBLEMS?

YES………NO………

DAMPNESS WITH COUGH ……..…. SNEEZE………….... RUN………………

URGENCY YES…………………… NO

OTHER EG PROLAPSE, SURGERY……………………………………………………………….......

...............................................................................................................................................

TREATMENT…………………………………………………………………………………………..

ABDOMINAL SEPARATION?

YES……….NO……………………

SIZE IN HOSPITAL IF KNOWN……………………………………………………………………

PREVIOUS EXERCISE HISTORY

……………………………………………………………………………………………………………

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EXERCISE GOALS.

1.……………………………………………………………………………………………………….....

2.…………………………………………………………………………………………………………

3………………………………………………………………………………………………………….

I AGREE TO THE TERMS AND CONDITIONS

YES NO