### NETHERLEY YOUTH & COMMUNITY INITIATIVE

# gym REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| personal details | | | | | | | | | | | | | | | | | | | | |
| Clients surname: | | | | | | | | Christian Name: | | | | | | ❑ Mr.  ❑ Mrs. | | | ❑ Miss  ❑ Ms. | | | |
|  | | |  | | | |
| Address | | | | | | | | | | | | Birth date: | | | | Age: | | | Sex: | |
|  |  | | | | | | | | | | | / / | | | |  | | | ❑ M | ❑ F |
| City | | | | Postcode: | | | | | | | Telephone No: | | | | Mobile No: | | | | | |
|  | | | |  | | | | | | |  | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| EMERGENCY CONTACTS: | | | | | | | | | | | | | | | | | | | | |
| **General Practitioner**:  Name: | | | | | | Address: | | | | | | | | Telephone No: | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | |
| Next of Kin Details: | | |  | |  |  | | | | | | | |  | | | | | | |
| Name: | | | | | Address: | | | | | | | | | Telephone No: | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| exercise goals? (if none, please state none) | | | | | | | | | | | | | | | | | | | | |
| Toning | | Weight Loss | | | Strength | | General Fitness | | | Classes | | | Gym Competitions | | | | | Other | | |
| Do you consider yourself to be a disabled person Yes ❑ No ❑ | | | | | | | | | | | | | | | | | | | | |
| ❑ Visual Impairment  ❑Mental Health Condition | | | | | ❑ Hearing Impairment  ❑Health Condition | | | | ❑ Physical Impairment  ❑ Multiple Impairment | | | | | ❑ Learning Disability  ❑ Prefer not to say | | | | | | |

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| FOROFFICAL USE ONLY  All persons who complete an induction must have had induction completed by qualified member of staff.  Administrator Name:  DATE: |

**HEALTH QUESTIONNAIRE**

1. Has your doctor ever said that you have had a heart problem?

❑ No ❑ Yes ……………………………………………………………………………………………

1. In the past month have you had any chest pain when  
   you were doing any activity No ❑ Yes ❑ You were resting No ❑ Yes ❑
2. Are you currently taking medication for   
   A heart condition No ❑ Yes ❑ ………………………………………………………………….  
   Any other problems No ❑ Yes ❑ ………………………………………………………………….
3. Do you suffer from any bone or joint problems?  
   No ❑ Yes ❑ ………………………………………………………………………………………..
4. In the past year have you had any major illness or major surgery?  
   No ❑ Yes ❑ …………………………………………………………………………………………..
5. Have you ever been diagnosed with  
   a). Diabetes No ❑ Yes ❑ b). Asthma No ❑ Yes ❑   
   c). Epilepsy No ❑ Yes ❑ d). Other problems No ❑ Yes ❑
6. Are you pregnant? No ❑ Yes EDD ………………………………………………………………….
7. Have you recently had a baby? No ❑ Yes ❑ how long ago? …………………………..
8. Do you ever  
   Lose your balance because of dizziness or lose consciousness No ❑ Yes ❑
9. Are you feeling unwell at present due to cold etc No ❑ Yes ❑

* **If you have answered YES to questions 1, 2, 3a, 5, 6c or 7 or feel that you may have a condition that may impair your ability to exercise effectively, we will require you to produce a doctors note prior to starting any exercises.**
* I have read, understood and completed this questionnaire and consider myself fit to exercise
* Any questions that I have answered are to my full satisfaction.
* I understand that I am exercising under my own volition.
* **If your health changes so that you may then answer YES to any of the questions above, tell a member of staff as soon as possible.**
* I will advise the staff of any health problems experienced whilst training.
* I take part in any exercises entirely at my own risk and waive any legal recourse for damage to myself or property arising from my participation.

Signature: …………………………………………………… Date: ……………………………………

**Please read the questions carefully and answer each one honestly, ticking the appropriate box or adding information as necessary. Your responses will of course be kept in the strictest confidence.**