

# GYM APPLICATION FORM

Starting Date: / /

Moama Sports Club Perricoota Road, Moama, NSW 2731  
 phone 03 5480 6444 fax 03 5480 6400  
 www.moamasportsclub.com.au

Weight: kgs



Membership Number Name

D.O.B. Age  Male  Female

Address Postcode

Contact Numbers Home Work Mobile

Email Address

Emergency Contact Name Relationship

Contact Numbers Home Work Mobile

Have you ever been, or are you currently affected by any of the following conditions?

**Category 1**

- Hypertention
- Respiratory Disorder
- Heart Trouble
- Stroke
- Blood Disorders
- Glandular Fever
- Epilepsy or Seizures
- Diabetes

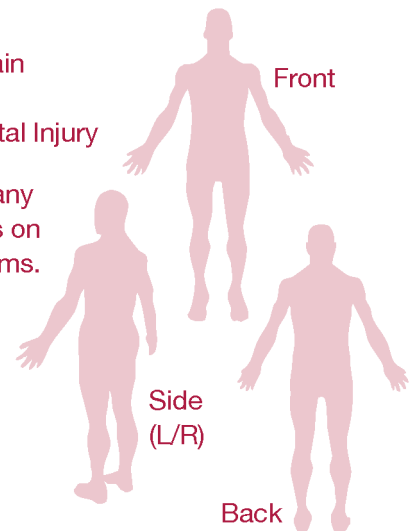
**Category 2**

- Pregnancy
- Prescription Medication
- Migraines
- High Cholesterol
- Any Surgery
- Asthma
- Hernia
- Exercise Allergies

**Category 3**

- Neck/Back Pain
- Joint Injury
- Musculoskeletal Injury

Please highlight any problem areas on body diagrams.



If you tick any of the above conditions please give dated details

\_\_\_\_\_

Are you aware of any other conditions not mentioned that may affect your training?  Yes  No, If yes add details.

\_\_\_\_\_

Client is aged 18-55 and has no risk factors	Clear for testing & exercise
Client indicated some category 1 conditions	Medical clearance needed from G.P.
Client indicated some category 2 conditions in last 12 mths	Medical clearance needed from G.P.
Client indicated some category 3 conditions in last 12 mths	Consult relevant health professional

**Privacy Statement:** Details on this form are strictly confidential & used by this centre solely for the purpose of health screening & program prescription. Access to this information by a third party will not occur without the client's written consent. I hereby give permission for the discussion of my training program to occur between the staff of the fitness centre and my G.P. (and/or) other allied health professionals as determined by the information detailed on this form.

Client's signature \_\_\_\_\_

Do you engage in any regular physical activity?  Yes  No  
 Would you describe your job as physical?  Yes  No  
 Have you recently been a member of another gymnasium?  Yes  No  
 If you have answered yes to any of the above, then please detail below

Sessions/Week 1 2 3 4 5 6 7    Session Duration 30min 45min 1hr  
 Indicate best days Mon Tues Wed Thur Fri Sat Sun All

Rank in order of importance from 1st - 3rd your exercise aims

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Muscle building          | <input type="checkbox"/> Fat Loss               | <input type="checkbox"/> Muscle Toning          |
| <input type="checkbox"/> Injury rehabilitation    | <input type="checkbox"/> Strength development   | <input type="checkbox"/> Cardiovascular Fitness |
| <input type="checkbox"/> Sports specific training | <input type="checkbox"/> Flexibility            |   |
| <input type="checkbox"/> Power training           | <input type="checkbox"/> Other - please specify |   |

Tick which types of activities you would like to include in your program to achieve these goals?

- |   |                                     |                                     |
|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Running/jogging        | <input type="checkbox"/> Weights    | <input type="checkbox"/> Skipping   |
| <input type="checkbox"/> Cross Training         | <input type="checkbox"/> Circuits   | <input type="checkbox"/> Rowing     |
| <input type="checkbox"/> Treadmill              | <input type="checkbox"/> Yoga/Lates | <input type="checkbox"/> Swiss Ball |
| <input type="checkbox"/> Other - please specify |                                     |                                     |

Do you eat the following meals regularly? What size meal would you usually have?

- |               |  |                 |   |
|---------------|--|-----------------|---|
| Breakfast     | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Small          |
| Morning Tea   | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Moderate       |
| Lunch         | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Large          |
| Afternoon Tea | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Very Large     |
| Dinner        | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Uncertain      |
| Supper        | <input type="checkbox"/> Yes <input type="checkbox"/> No | or Occasionally | <input type="checkbox"/> Meals per day? |

Do you drink alcohol?  Yes  No    If so how many / week \_\_\_\_\_

Do you smoke "including socially"  Yes  No    If so how many / week \_\_\_\_\_

How often do you eat the following?

- |                      |                       |                                     |                       |
|----------------------|-----------------------|-------------------------------------|-----------------------|
| Fruit/Vegetables     | _____ serves/day/week | Water                               | _____ glasses / day   |
| Fried / Fatty foods  | _____ serves/day/week | Milk & Dairy Produce                | _____ serves/day/week |
| Meat / Poultry       | _____ serves/day/week | Breads & Cereals                    | _____ serves/day/week |
| Soft Drinks eg. Coke | _____ cans/day/week   | Highlight the relevant unit of time |                       |

As part of your fitness evaluation and to assist us in designing your program, you may be asked to perform a series of tests and exercises. In order to minimise your risk of injury during these tests and your future training sessions, we rely on the accuracy of the information supplied to us on this form. If you believe this information to be accurate and agree to notify a staff member should any of this information change, please sign below.

Client's signature \_\_\_\_\_

Evaluator's signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

How did you hear about us?

- |  |  |                                      |                                |                                 |                                  |
|--|--|--------------------------------------|--------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> The Premier   | <input type="checkbox"/> The Riverine Herald           | <input type="checkbox"/> Television  | <input type="checkbox"/> Radio | <input type="checkbox"/> E-Mail | <input type="checkbox"/> Website |
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Moama Sports Club Advertising | <input type="checkbox"/> Other _____ |                                |                                 |                                  |