



Run Clinic Information Form

Name: _____

Phone #: _____

Address: _____ City: _____

Emergency contact _____ ph.# _____

Male ___ Female ___ Date of Birth: _____

Email (for clinic info updates) _____

Shirt Size: XS S M L XL XXL

My fitness goals are:

1 _____

2 _____

3 _____

I heard about this program: _____

My experience with the centre is:

I am new to the centre _____

I have taken programs here before _____

I live within ?km from the centre:

Walking distance <5km 5-10km >10km

3 things I'd like to do in my life:

1 _____

2 _____

3 _____

Health Screen

Name: _____

Date of Birth: _____

Do you suffer from any of the following:

Heart disease..... Yes No

High Blood Pressure..... Yes No

Diabetes..... Yes No

Asthma..... Yes No

Epilepsy..... Yes No

Hypoglycemia..... Yes No

Arthritis..... Yes No

Often feel faint or have spells of severe dizziness... Yes No

Have you recently had any surgery?..... Yes No

If yes, explain _____

Do you have a history of back trouble?..... Yes No

If yes, explain _____

Have you recently or are you currently injured?..... Yes No

If yes, explain _____

Are you receiving treatment/training for an injury?... Yes No

If yes, explain _____

Are you pregnant?..... Yes No

Do you have any other medical condition that may affect your participation in a fitness test or exercise program?..... Yes No

If yes, explain _____

I am aware and appreciate that there are risks of injury involved in my participation in fitness testing and physical activity. If you answered yes to one or more of the questions above, it is your responsibility to consult your physician before starting a fitness program. The information on this form will be kept confidential. Please sign the form below to indicate that you have read and understand this form and that you are responsible for consulting with your physician.

Signature

Date