



**Exercise History and Safety Questionnaire**

Name \_\_\_\_\_ Surname \_\_\_\_\_ Sex: M  F

Address \_\_\_\_\_

Suburb \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Telephone (h) \_\_\_\_\_ (w) \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Please add my email to your Reality SDC distribution list  Date of Birth \_\_\_\_\_

<b>In case of emergency please contact:</b>	<b>Your T-shirt size:</b>
Name: _____ Relationship _____	Tel: _____

**How did you hear about Reality Self Defence and Conditioning?**

Newspaper  Flyer/Poster  Yellow Pages  Word of Mouth  Internet

Other please specify \_\_\_\_\_

**Please list any martial arts experience that you may have:**

Style \_\_\_\_\_ Years \_\_\_\_\_ Style \_\_\_\_\_ Years \_\_\_\_\_

**Are you employed in an industry related field?**

Fitness and Health  Law Enforcement  Security  Military  Other \_\_\_\_\_

**Exercise Safety Questionnaire**

For Your Safety: Please answer the following questions by ticking the appropriate box, and read the exercise advice below.

Tick to answer	No	Yes
1. Have you ever had any illness, injury, back or joint condition that may be aggravated by vigorous exercise		
2. Have you ever had: Arthritis, Asthma, Diabetes, Epilepsy, Hernia, Dizziness, Gout, Ulcer or Circulation Problems		
3. Have you ever had a heart condition, high blood pressure, rheumatic fever, stroke, high cholesterol, palpitations, murmurs or pains in the chest		
4. Have any of your family members had any heart problems?		
5. Are you now or have recently been pregnant?		
6. Are you taking any prescribed or non prescribed medications?		
7. Have you had any joint replacement surgery or surgery in the previous 12 months?		
8. Do you have any untreated joint or muscle injury, or persistent symptoms after a joint or muscle injury		

9. Are you a smoker, heavy drinker or recreational drug user?		
10. Is there any other condition that might be reason to modify your exercise program?		
11. Have you been doing regular vigorous exercise lately? If YES, what type of exercise?		
12. Have you had a check up with your G.P. in last 6 months? (Compulsory) Please attach to your questionnaire		
13. How would you describe your current physical condition? <input type="checkbox"/> Unwell <input type="checkbox"/> Overweight <input type="checkbox"/> Unfit <input type="checkbox"/> Healthy <input type="checkbox"/> Fit		
14. What are they main benefits that you want from exercise? <input type="checkbox"/> Fat loss <input type="checkbox"/> Muscle tone <input type="checkbox"/> Increase size <input type="checkbox"/> Enjoyment <input type="checkbox"/> Stress Relief <input type="checkbox"/> Improve fitness <input type="checkbox"/> Maintain fitness <input type="checkbox"/> Sport training <input type="checkbox"/> Good health		
15. Because of the nature of the material taught in Defensive tactics classes we do a background check on all students/clients prior to commencement of training. We reserve the right to not provide training to individuals who do not answer this question or have a criminal history of violence related convictions. Please answer honestly. This material is both private and confidential and will not be shared with any outside parties.  Do you have a criminal record? <input type="checkbox"/> Yes <input type="checkbox"/> No    If you answered yes please provide details of your record and convictions:            		

Congratulations on taking the first step to the path of self development. If you are a beginner work at a slow pace and learn how to do the techniques and exercises correctly. Please ask your instructor for guidance if you are injured or unsure of any techniques or exercises. Remember you are responsible for the safety of your partner as well as yourself.

I have completed the Exercise History and Safety Questionnaire honestly and to the best of my ability.	
Signed:	Date:
Witness:	Date: