

Welcome to C2K

Here at C2K, we aim to provide you with the relevant membership information that will serve your health and fitness needs. Please answer the following questions to assist us in this process

1. CUSTOMER INFORMATION

Title Mr Mrs Miss Ms Dr

First Name:

Surname:

Date of Birth:

Street Address:

Suburb:

Post Code:

Phone - Home:

Phone - Mobile:

Email Address:

2. MEDICAL INFORMATION

Please tick if you have had, or have any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Faint or dizzy spells |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pacemaker/Stent | <input type="checkbox"/> Swollen feet/ankles |
| <input type="checkbox"/> Bone or Joint problems | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other: | |

If you ticked Yes to any of the above, we recommend obtaining a Medical Clearance before beginning your exercise program

Is your doctor aware of your intention to exercise? Y / N

Doctors Name:

3. EXERCISE HISTORY AND RESULTS

General

Have you been to a Fitness Centre before?

Y / N

If Yes how long has it been (within the last...)

Week Month 6 months Year Longer

How long have you been thinking about starting an exercise program?

Results

What results do you want to achieve (please tick);

- | | |
|--|---|
| <input type="checkbox"/> Stress management | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Improve muscle tone | <input type="checkbox"/> Increase energy levels |
| <input type="checkbox"/> Increase fitness | <input type="checkbox"/> Sports conditioning |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Strength training |
| <input type="checkbox"/> Other: | |

Goals

How important is it to achieve your goals?

Moderately Very Important A definite priority

How many visits per week would you make in order to achieve your goals?

1-2 visits 2-3 visits 4+ visits

4. HOW DID YOU HEAR ABOUT US?

- | | | |
|---------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Internet/Web | <input type="checkbox"/> News Paper | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Direct Mail | <input type="checkbox"/> Coupon | <input type="checkbox"/> RSL |
| <input type="checkbox"/> Sign | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |
| <input type="checkbox"/> Referral | Name: | |

5. STATEMENT

I understand that C2K is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. I will not hold C2K liable in any way for any injuries that may occur while I am on these premises.

Signature:

Date:

Staff:

C/C Issued: Y / N