Full Name

Email Address

Gender

Street Address

City

Province/Region

Zipcode

Country

Date of Birth

☐ I agree to these terms.

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? *

☐ Yes ☐ No

In the past month, have you had chest pain when you were not doing physical activity? *

☐ Yes ☐ No

Do you feel pain in your chest when you do physical activity? *

☐ Yes ☐ No

Do you lose your balance because of dizziness or do you ever lose consciousness? *

☐ Yes ☐ No

Do you have a bone or joint problem (for example, neck, shoulder, back, knee or hip) that could be made worse by a change in your physical activity *

☐ Yes ☐ No

Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure, cholesterol or heart condition? *

☐ Yes ☐ No

Are you at least 6 weeks postpartum and have been cleared by Doctor or Midwife to resume exercise? *

☐ Yes ☐ No

Do you know of any other reason why you should not do physical activity? *

☐ Yes ☐ No

Has anyone under the age of 40 in your immediate family experience sudden cardiac arrest? *

☐ Yes ☐ No

If you answered yes to any questions please explain:

Sign your name below:

Please read the Electronic Records and Signature Disclosure

☐ I agree to use electronic records and signatures