



OFFICE USE ONLY	
Date:	Receipt#
Amount Paid:	Consultant:
Shirt Size:	Verified:
Photo/Measure/Time/Date:	Website Username:
C/C Visa/Master:	Website Password:
Card#	
Validation:	

PRE-TRANSFORMATION CONFIDENTIAL SCREENING FORM

CLIENT PROFILE

Surname:	Given Name:	Title:
Male/Female:	D.O.B.:	Age:
Address:		
Suburb:	Postcode:	
Home Ph.:	Mobile No.:	
Work Ph.:	Email:	
Emergency Contact:	Relationship:	Ph. No.:
How did you hear about this Sydney Survivors Transformation?		
Website <input type="checkbox"/>	Friend/Relative <input type="checkbox"/>	Facebook <input type="checkbox"/> Ad where? <input type="checkbox"/> Other <input type="checkbox"/>
If other, please specify:		

PRE-EXERCISE SCREEN

Do you have a history of any of the following health conditions?			
Health Condition	Yes	No	If yes, please specify:
Family history of heart disease, stroke, raised cholesterol, or sudden death?	<input type="checkbox"/>	<input type="checkbox"/>	
Low or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition or murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory condition (incl. asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness or fainting?	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis/arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Gout/hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	
Liver/kidney conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

Are you, or have you recently had or done any of the following?			
	Yes	No	If yes, please specify:
Are you over 35 (male) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you over 45 (female) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently pregnant or have you given birth in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been hospitalised recently?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you/have you suffer from any infections or infectious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you/have you been dieting or fasting?	<input type="checkbox"/>	<input type="checkbox"/>	



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PRE-EXERCISE SCREEN

Do you have a history of any of the following health conditions?			
Health Condition	Yes	No	If yes, please specify:
Family history of heart disease, stroke, raised cholesterol, or sudden death?	<input type="checkbox"/>	<input type="checkbox"/>	
Low or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition or murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory condition (incl. asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>	
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Osteoporosis/arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Gout/hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	
Liver/kidney conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

Are you, or have you recently had or done any of the following?			
	Yes	No	If yes, please specify:
Are you over 35 (male) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you over 45 (female) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently pregnant or have you given birth in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been hospitalised recently?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you/have you suffer from any infections or infectious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you/have you been dieting or fasting?	<input type="checkbox"/>	<input type="checkbox"/>	

Please Note: If you have answered YES to any of the above questions OR you are NOT SURE – we strongly recommend that you see a Doctor prior to participating in the Transformation.

Have you ever had or do you have any condition, pain, or major injuries in the following areas which may be reason to modify your exercise program?
Neck <input type="checkbox"/> Knees <input type="checkbox"/> Back <input type="checkbox"/> Ankles <input type="checkbox"/> Shoulders <input type="checkbox"/> Pelvis <input type="checkbox"/> Other <input type="checkbox"/>
If you answered yes to any of the above, please specify:
Have you had any major surgery?
Yes <input type="checkbox"/> No <input type="checkbox"/>
If you answered yes, please specify (including when):
Are there any other conditions not mentioned above which may be a reason to modify your exercise program?
Yes <input type="checkbox"/> No <input type="checkbox"/>
If you answered yes, please specify:
Do you smoke cigarettes?
Yes <input type="checkbox"/> No <input type="checkbox"/>

On a scale of 1-10 how would you rate your current fitness level (please circle)?

1 2 3 4 5 6 7 8 9 10
Very Poor Average Excellent

SYDNEY SURVIVORS 10 WEEK TRANSFORMATION **TERMS AND CONDITIONS**

During the **Sydney Survivors 10 Week Transformation**, every effort will be made to ensure the safety of all participants. However, as with any exercise program, there are certain risks, including increased heart stress and the chance of musculoskeletal injuries.

As per Fitness Australia standards it is recommended that all males over the age of 35 and females over the age of 45 have a medical assessment including an exercise ECG and cholesterol lipid count. Participants in either of these categories who **DO NOT** have a Doctor's examination prior to taking part in the Sydney Survivors 10 Week Transformation **MUST ACKNOWLEDGE** that that they have been informed of its importance.

CONDITIONS OF ENTRY

You must complete at least one paid session per week for the duration of the Sydney Survivors 10 Week Transformation to be eligible for awards/prizes and entry to the Awards Dinner.

INDEMNITY CLAUSE

- I recognise that participation in the Sydney Survivors 10 Week Transformation involves the risk of injury to my person or property.
- I acknowledge that whilst I participate I do so at my own risk.
- I agree that if I suffer an injury prior to or during the Sydney Survivors 10 Week Transformation, I will immediately inform a Sydney Survivors Representative and complete an Accident Injury Form.
- I release, indemnify, and hold harmless the Personal Trainer operator, its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf by other parties for, or in respect of or arising out of any injury, loss, damage or death caused to me or my property whether by negligence, breach of contract or in any other way whatsoever.
- I also agree that in the event that I am injured or my property damaged, I will bring no claim legal or otherwise against the Personal Training operator in respect of that injury or damage.

I have read and fully understood the terms and conditions for participating in the **Sydney Survivors 10 Week Transformation** on this application **INCLUDING the Indemnity Clause** and I agree to abide by and accept these conditions for the period of time in which I participate in the Transformation.

Client Name: _____ **Date:** _____

Client Signature: _____ **Representative Signature:** _____

**For more information check out our website at www.sydneyurvivors.com.au
Contact us at transformations@sydneyurvivors.com.au or on 95450001**

