



*Island City, by Nature*

**Healthy Back & Strong Abdominals Screening Questionnaire & Consent Form**  
(Program takes place at Minoru Pavilion)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Person to contact in case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

How did you find out about this program? \_\_\_\_\_

Describe your current physical activity and exercise program \_\_\_\_\_

Does your Physician know that you are taking this program? \_\_\_\_\_

**Health History (please complete the following)**

1) Have you ever seen a doctor regarding back pain before? \_\_\_\_\_ If yes, what was diagnosed? \_\_\_\_\_

2) Do you presently suffer from acute back pain? No Yes

3) Are you currently receiving treatment for back pain? No Yes

4) Have you had a surgical operation on your back? No Yes If yes, please explain: \_\_\_\_\_

5) Do you ever have morning stiffness in your back? No Yes

6) Can you get down on the floor and get back up with minimal pain? No Yes If no, please explain: \_\_\_\_\_

7) How often do you experience back pain?  rarely  frequently  all the time

8) How long can you sit or stand without pain? Sit \_\_\_\_\_ Stand \_\_\_\_\_

9) How far/long can you walk without pain? \_\_\_\_\_

**Health History (please complete the following)**

- 10) Do you experience any of the following:
- a) Radiating pain
  - b) Numbness and Tingling
  - c) Loss of function
  - d) Swelling
  - e) Night pain
- 11) My back pain affects me by please check the ones which apply:
- a) No affect on daily living
  - b) Occasionally limits certain movements
  - c) Causes occasional absence from work
  - d) Causes regular absence from work
  - e) Requires frequent or constant rest
- 12) Do you currently participate in a regular form of exercise (3-4 times per week for 20 minutes or more)?  
If yes, please indicate the type of activity you do: \_\_\_\_\_
- 13) Do you have Diabetes? \_\_\_\_\_ If yes, Type I  Type II  Boarder-line
- 14) Do you take Insulin? No Yes (*Please bring your blood glucose monitor to class each time*)
- 15) Heart problems, chest pain? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- 16) High blood pressure (hypertension)? \_\_\_\_\_ If yes, \_\_\_\_\_
- 17) History of breathing or lung problems? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- 18) Arthritis? \_\_\_\_\_ If yes, type of Arthritis and area affected: \_\_\_\_\_
- 19) Muscle or joint disorders? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
- 20) Hernia, or any condition that may be aggravated by lifting weights? \_\_\_\_\_ If so, please explain: \_\_\_\_\_  
\_\_\_\_\_
- 21) Are you currently on any medications or drugs? \_\_\_\_\_ If so, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Participant Informed Consent Form**

I understand that the Richmond Healthy Back and Strong Abdominal program will provide me an physical activity program. The activities included in my exercise program will be designed to place a gradually increasing workload on the cardiovascular system. I understand that the reaction of the system to such activities cannot always be predicted with complete accuracy and therefore there is a risk associated with exercising. I also understand and accept that these risks may occur during or following an exercise session. I understand and accept the risks of participating in any physical activity, including the risks resulting from my participating in the Richmond Healthy Back and Strong Abdominal physical activity program, and that I may suffer personal injury while participating in the program.

By signing this release, I assume all the risks of injury, loss, or expense of any kind resulting from my participation in the program. I will not hold the Richmond Fitness and Wellness Association, City of Richmond or the staff associated with the program, liable for any injury, loss, or expense suffered as a result of my participation. This release will apply to each and every session that I participate in the program.

*I have read, understood, and fully agree to the foregoing. Any questions I had have been answered to my satisfaction.*

Signed on the \_\_\_\_\_ day of (month) \_\_\_\_\_, 20 \_\_\_\_\_

By: \_\_\_\_\_  
**Participant’s signature** **Print name**

*(Dear Participant, you may require a Physician’s consent, please read below)*

**Physician Referral Form Activity Readiness Conveyance**

Your patient is interested in registering for the “Healthy Back and Strong Abdominal” physical activity program. The participant will learn the importance of conditioning the muscles and joints that support their back and keep in a healthy balance throughout the day. As part of the registration process, your client has answered “yes’ to four or more of the Health History questions and requires medical clearance in order to participate. Please identify any recommendations or registrations for your patient’s fitness program below:

Based upon a current review of the health status of \_\_\_\_\_, I recommend:

Avoidance of: \_\_\_\_\_

Unrestricted physical activity start slowly and build up gradually: \_\_\_\_\_

Additional comments: \_\_\_\_\_

A1C: \_\_\_\_\_ Date: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician’s signature:** \_\_\_\_\_ **Ph:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(If you have any questions about the Healthy Back and Strong Abdominals physical activity program,, please contact the Minoru Pavilion Office 604-718-8004 )*