25 Padstow Street,
Raceview,
Alberton

Wellness

Cell: 082 854 4874
081 721 0870
Tel: 011 907 5096
bfitwellnessinfo@gmail.com

Discovery membership number | | | | | | | | | | | | | | |

I,______________________________________, do hereby consent to health screening as part of the Vitality Fitness Assessment.

I understand that it will include my results from the online fitness assessment medical and family history, measuring my blood pressure, height and weight, waist circumference and body fat percentage as well as a physical activity component consisting of a step test, push-ups, flexibility test and a Bio movement assessment.

I acknowledge that this is a screening assessment and should any of my tests fall outside of normal parameters, I am responsible for monitoring further investigations that can be required.

I participate in the Vitality Fitness Assessment voluntarily and do not hold Discovery Vitality or the healthcare professional liable for any damage or injury caused while doing so.

I agree that Discovery Vitality and its contracted research partners may use the results from the Vitality Fitness Assessment for statistical and research purposes. Data will be anonymised.

For Pregnancy*I understand that the assessment is not suitable for pregnant women and that Discovery Vitality will not be liable for any injury to myself or my unborn child should I request the Bio to perform the assessment while I am pregnant

Signed this________________ day of_________________ 20_____ Signature _____________________________

Section 1		Patient Details	
First Names			
Surname			
Identity no.		DOB	D D M M Y Y Y Y
Medical Aid		Cell no	
Medical Aid No.		Work no	
Dep. No.		Home no	
Email			

Section 2	Measurements	FOR OFFICE USE	
Height	cm	**Tricep**	mm
Weight	kg	**Supra-iliac**	mm
Waist	cm	**Abdominal**	mm
Blood Pressure	mmHg	**Thigh**	mm
Resting Heart Rate	bpm	**Push ups**	reps
Recovery HR (1min)	bpm	**Sit and Reach**	cm

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Section 3 Family History	Please X	Age?
Have any of your immediate family members suffered from?		
Cancer	YES	
Diabetes	YES	
Heart disease	YES	
High Blood Pressure	YES	
COPD	YES	
High Cholesterol	YES	
Osteoporosis	YES	
Stroke	YES	
None	YES	

Section 4 Personal Medical History	Please X	Medication?	Treatment?
Do you or have you ever suffered from? **(as diagnosed by a health care practitioner)**			
Asthma	YES		
Arthritis	YES		
Back Pain	YES		
Cancer	YES		
Chronic Obstructive Pulmonary Disease	YES		
Clotting Disorder	YES		
Depression	YES		
Diabetes	YES		
Epilepsy	YES		
Heart Disease	YES		
High Blood Pressure	YES		
High Cholesterol	YES		
Osteoporosis	YES		
Stroke	YES		
Thyroid Disease	YES		
None	YES		

You are physically inactive (ie you get less than 30 minutes of physical activity on at least 3 days a week)

You have a body mass index equal or greater than 30 kg/m2

If one or more of the phrases above is ticked, you are advised to consult your doctor before starting a vigorous-intensity exercise program. You may begin light-to-moderate intensity exercise such as walking without/before consulting your physician, but please progress gradually with your exercise program.

Waiver: I understand that the answers I have given to the questions about my health may indicate a potential health risk in relation to exercise. I have been advised to consult my doctor to discuss my answers with him/her before starting an exercise program or increasing my physical activity.

Signed _____ Y Y Y Y M M D D

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Section 5 Personal Medical Risks	Please X
Have You ever had any of the following?	
A Heart Attack	YES
Heart Surgery	YES
Cardiac Catheterization	YES
Coronary Angioplasty	YES
Pacemaker, Implantable Cardiac Defibrillator or Rhythm Disturbance	YES
Heart Valve Disease	YES
Heart Failure	YES
Heart Transplant	YES
Congenital Heart Failure	YES
Have you ever experienced the following symptoms?	
Chest Discomfort With Exertion	YES
Unreasonable Breathlessness	YES
Dizziness ,Fainting or Blackouts	YES
Ankle Swelling	YES
Unpleasant Awareness of a Forceful or Rapid Heart Rate	YES
You Take Heart Medications	YES
Have you ever had health issues such as:	
Diabetes	YES
Asthma or other Lung Disease	YES
A burning or cramping sensation in your lower legs when walking short distances	YES
Any muscle or joint problems that limit your physical activity/ that could be aggravated by physical injury	YES
Have any concerns about the safety of exercise	YES
Take prescription medication(s)	YES
Which of the following describes you?	
You are a man older than 45 years	YES
You are a woman older than 55 years	YES
You smoke or quit smoking within the previous 6 months	YES
Your blood pressure is equal or greater than 140/90 mmHg	YES
You don't know your blood pressure	YES
You take blood pressure medication	YES
Your blood cholesterol level is greater than 200 mg/dL (greater than 5.2 mmol/l)	YES
You don't know your cholesterol level	YES
You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)	YES
You have pre-diabetes	YES
You do not know if you have pre-diabetes	YES
You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week)	YES
You have a body mass index = or > 30kg/m2	YES

Form completed

Lunge Test

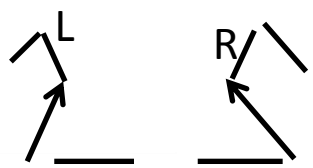
L_____

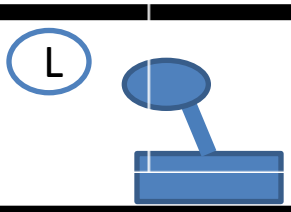
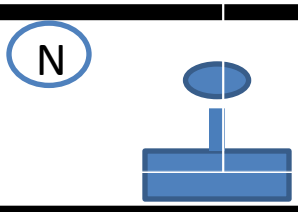
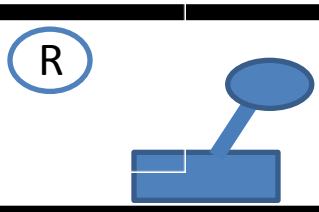
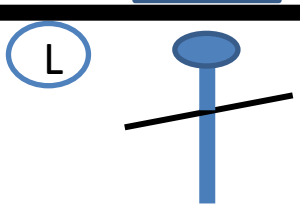
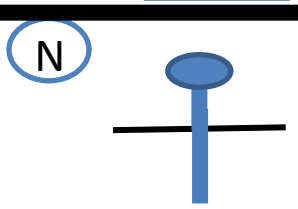
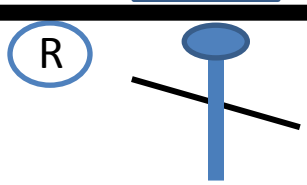
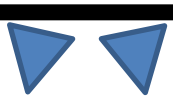
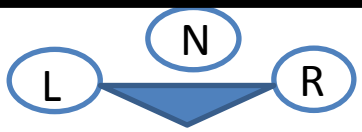
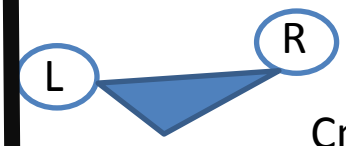
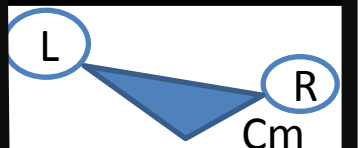
R_____

Balance

	Open Eyes	Closed Eyes
Left		
Right		

Shoulder



Head Tilt			
Shoulder slant			
Scapulae	 Normal	 Wide Apart	 Winging
Scoliosis	 C-Shaped Left	 C-Shaped Right	 S-Shaped	 Normal
Hip alignment		 Cm_	 Cm__
Knees	 Normal	 Knock ___ 5	 Bow ___ 5
Head (lat view)	 Normal	 Slightly Forward _____ 5	
Shoulders & U Back(lat view)	Normal	Slouch	Kyphopsis
Lower Back (lat view)	Normal	Back Flat	Anterior Tilt	Lordosis