



## HEALTH SCREEN QUESTIONNAIRE

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

Given Name: \_\_\_\_\_ Family Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

D.O.B (DD/MM/YYYY): \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ State: \_\_\_\_\_ P/code: \_\_\_\_\_

Occupation: \_\_\_\_\_ How did you hear about myBrazilian Jiu Jitsu?: \_\_\_\_\_

Emergency Contact – Name: \_\_\_\_\_ Emergency Contact – Phone: \_\_\_\_\_

### About Your Training (please circle ALL that apply):

**Goals:** Fitness / Weight-Loss / Martial Arts Knowledge / Social / Fun / New Challenge / Competition

**Gym Member:** Yes / No      **Gym Interests:** Weights / Cardio / Classes / Personal Training

**Martial Arts:** Never trained before / Trained Martial Arts before / Currently training

*If you selected 'Trained Martial Arts before' or 'Currently Training' please state:*

Particular Style: \_\_\_\_\_ Grade Achieved: \_\_\_\_\_

Number of year(s) studied: \_\_\_\_\_ School / Academy: \_\_\_\_\_

*The MyBJJ Team thank you for taking the time to complete this questionnaire as recommended by Fitness Australia, Exercise and Sports Science Australia (ESSA) and Sports Medicine Australia (SMA). Please answer each question carefully as this information will contribute to the quality & safety of your training.*

### Known Diseases (Medical Conditions), Signs & Symptoms

List the medications for medical conditions you take on a regular basis: \_\_\_\_\_

#### Do you suffer from any of the following?

- |                          |          |
|--------------------------|----------|
| 1. Diabetes              | Yes / No |
| 2. Heart problems        | Yes / No |
| 3. Angina                | Yes / No |
| 4. High Blood Pressure   | Yes / No |
| 5. Convulsions           | Yes / No |
| 6. Dizzy Spells/Fainting | Yes / No |
| 7. High Cholesterol      | Yes / No |
| 8. Lung Disorder         | Yes / No |
| 9. Epilepsy              | Yes / No |
| 10. Seizures             | Yes / No |
| 11. (Women) Pregnant?    | Yes / No |

#### In the past 12 months have you experienced:

- |                         |          |
|-------------------------|----------|
| 1. Concussion           | Yes / No |
| 2. Severe cramps        | Yes / No |
| 3. Persistent Nausea    | Yes / No |
| 4. Muscle Pain/Soreness | Yes / No |
| 5. Joint Pain/Soreness  | Yes / No |

Do you have any allergies? Yes / No \_\_\_\_\_

Are you aware of any medical reason that might prevent you from participating in exercise? Yes / No \_\_\_\_\_

*If you answered yes to any statements in Stage 1 or 2 on this page it is recommended you consult your Medical Practitioner or appropriate Allied Health Professional before engaging in exercise. You may be requested to provide a medical clearance before commencing exercise. By signing this form, I acknowledge that I read & understood this waiver. I acknowledge that I have no injuries, physical restrictions, disabilities or any predispositions to sickness or injury, which may be aggravated or adversely affected as a result of my participation. I acknowledge & recognize that martial arts training (Brazilian Jiu Jitsu, Judo, Submission Grappling & Mixed Martial Arts – including children's martial arts) may be a hazardous activity & therefore I train at my own risk & will not seek to penalize, prosecute or claim compensation from the organizers, sponsors, trainers or participants of the programs for any injury, loss or damages. **The information in this form is strictly confidential** & subject to laws & regulations contained in the Privacy Laws, enacted December 2001.*

Signed (Member/Guardian): \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signed (Staff): \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_