



If possible please return form prior to first session  
 Email: [info@tribalfitnessbootcamps.co.uk](mailto:info@tribalfitnessbootcamps.co.uk)  
 Tel: 07825 162646

## Registration Form

### About you

Name \_\_\_\_\_ D.C \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Home Tel number \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency contact name & number \_\_\_\_\_

Relationship to you \_\_\_\_\_

Dr (name, address & tel) \_\_\_\_\_

Health Visitor (name) \_\_\_\_\_

Where did you have your baby? \_\_\_\_\_

Baby's name (boy/girl) \_\_\_\_\_ Baby's D.O.B. \_\_\_\_\_

Please tick the reason/s you are attending Pramtastic Bootcamp. *(if more than one please circle the main reason)*

Lose weight	<input type="checkbox"/>	Lose inches	<input type="checkbox"/>	Adapt a healthier lifestyle	<input type="checkbox"/>
Maintain weight	<input type="checkbox"/>	Make friends	<input type="checkbox"/>	To get out of the house	<input type="checkbox"/>
Improve fitness	<input type="checkbox"/>	Have some 'me' time	<input type="checkbox"/>	Boost your energy levels	<input type="checkbox"/>
Maintain fitness	<input type="checkbox"/>	Tone body	<input type="checkbox"/>	Build confidence & self esteem	<input type="checkbox"/>
Improve posture	<input type="checkbox"/>	Improve your mood	<input type="checkbox"/>	Regain pre-pregnancy condition	<input type="checkbox"/>
Gain strength	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>		

How often do you exercise? \_\_\_\_\_ times per week \_\_\_\_\_ times per month  never

What type of exercise is this? (e.g. gym) \_\_\_\_\_

Would you consider yourself to be a:  Beginner  Intermediate  Advanced

Do you smoke? No/Yes \_\_\_\_\_ per day

How did you hear about Tribal Fitness Bootcamps? \_\_\_\_\_

I agree to be photographed and videoed for the purposes of Tribal Fitness and agree for these to be used on any promotional material including print and online.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

*Your details will be securely kept. They are for the use of Tribal Fitness only and will not be shared with any other third party.*

## Health Screening

Please read carefully and answer each question, giving any further details in the space provided at the bottom if necessary. If you are unsure of any question, please contact Tribal Fitness on 07825162646

		YES	NO
1	Is this your first baby? (if yes, go to question 4)	<input type="checkbox"/>	<input type="checkbox"/>
2	In previous pregnancies, did you have any medical problems either during the pregnancy or after delivery?	<input type="checkbox"/>	<input type="checkbox"/>
3	What type of delivery did you have with any previous births? (circle)	Vaginal	Forceps    Vontous    Caesarean
4	In this pregnancy, have you had any medical problems either during the pregnancy or after delivery?	<input type="checkbox"/>	<input type="checkbox"/>
5	What type of delivery have you had with this birth? (circle)	Vaginal	Forceps    Vontous    Caesarean
6	How long has it been since the birth?	_____	
7	Have you stopped bleeding/having discharge?	<input type="checkbox"/>	<input type="checkbox"/>
8	Have you had your post natal check-up? (usually 6-8 weeks)	<input type="checkbox"/>	<input type="checkbox"/>
9	Has your doctor or midwife given you consent to exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10	Do you have a history of heart/lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
11	Have you ever had chest pains or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>
12	Do you have high/low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
13	Do you suffer from headaches/fainting/dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
14	Do you have any illness/disability/joint problem or injury that may affect you during exercise? E.g. epilepsy/diabetes/damaged knee ligaments	<input type="checkbox"/>	<input type="checkbox"/>
15	Are you on any medication? If yes, please give details and state if it will affect you during exercise.	<input type="checkbox"/>	<input type="checkbox"/>
16	Have you been recommended to exercise by a health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
17	Have you ever been told to avoid exercise, for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
18	Do you know of any other reason why you should not exercise?	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to give further details, along with any other information that you feel is necessary.

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### Informed Consent

I hereby state that I have read, understood and answered honestly the pre-exercise health screening questionnaire. Any questions I had were answered to my full satisfaction. I confirm that the information I have provided is true and agree to inform the instructor if there are any changes in my medical condition. I also understand that it is advisable to seek medical approval before starting any exercise programme. I recognise that whilst every effort is made to keep the class safe and enjoyable, I understand that all forms of exercise come with a varying degree of risk to musculoskeletal and/or cardio-respiratory systems. I clarify that I am participating of my own free will and understand, as with any exercise programme, there is a risk of injury and agree to waive, release and discharge Tribal Fitness of any claims, damages and losses, including death as a result of participating in Tribal Fitness exercise sessions.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_