Registration Form

We would like to get to know you a little bit better by asking you to complete this registration form. This information will be kept confidential. ***You may choose not to answer any question***. Your answers to some of the questions help us to design the programs to meet the needs of the community.
Thank you for your time!

➔ **Name:** ____

➔ **Address:** ____

➔ **Phone Number:**_______________________________________

➔ **E-mail address:** ______________________________________

➔ **Age:** ________ ➔ **Birthdate:** (day/month/year) ______________

In case of emergency, please contact:
Name: __________________________ Phone Number: ____________

➔ **Are you?** Male or Female (please circle)

➔ **How many classes per week are you interested in attending?**

❒ 1 ❒ 2 ❒ 3 ❒ more than 3

➔ **What time of day would you prefer the class to start?**

❒ morning Suggested start time for class? __________
❒ afternoon Suggested start time for class? __________
❒ evening Suggested start time for class? __________

➔ **What location(s) would you prefer to attend class?**
Please check (✓) all that apply.

❒ Beachburg ❒ Cobden ❒ Perreton
❒ Foresters Falls ❒ Westmeath ❒ Douglas

Part A: About you

1. How did you hear about this program?

   ❒ Community Health Centre Offices
   ❒ Posters
   ❒ Radio, please list stations ___________________________________
   ❒ Newspaper Ad
   ❒ Coming Events in the newspaper
   ❒ Website
   ❒ Health Happenings newsletter
   ❒ Other newsletter(s), please list _______________________________
   ❒ Other (Please describe below)

   ____

2. If you wanted to get information about the fitness classes i.e. when classes start in the fall, class locations etc. where would you look for it? (Please check (✓) all that apply)

   ❒ Community Health Centre Offices
   ❒ Posters
   ❒ Radio, please list stations ___________________________________
   ❒ Newspaper Ad
   ❒ Coming Events in the newspaper
   ❒ Website
   ❒ Health Happenings newsletter
   ❒ Other newsletter(s), please list _______________________________
   ❒ Other (Please describe below)

   ____

3. Do you know anyone else in this program?

   ❒ Yes ❒ No

4. How do you normally travel to the fitness class? Please check (✓) one.

   ❒ My own car ❒ Ride with family or friend
   ❒ Other (Please describe below)

   ____

5. Have you come to a fitness class before?

   ❒ Yes ❒ No

   If yes, what type of class was it? Please describe below.

   ____

6. How sure are you that you would be able to do the exercises in this program? (Please circle the number).

5	4	3	2	1
Very Sure	Pretty Sure	Undecided	Not very sure	Very unsure

7. Do you have any concerns about participating in this program? Please put a check (✓) in the box beside all that apply.

   ❒ No
   ❒ I may not have the skills to keep up
   ❒ I may not be able to schedule the time to attend the classes
   ❒ I may have trouble traveling to the classes
   ❒ Other (please describe below)

   ____

Part B: About your current activities

8. Other than this class, are you currently registered in any other organized physical activity classes or programs that meet regularly?

   ❒ Yes ❒ No

If yes to question #8, please list the activities below. If “no,” go to question #9.

Class/Group/Program Description	Number of times per week you attend	Length of session (minutes)	Location

9. Do you exercise at home?

❒ Yes ❒ No

If “yes,” please list the activities below, if “no,” go to question #10.

Type of activity	Number of times per week	Length of session (minutes)

10. Are there any other activities that you enjoy? (i.e. golf, curling etc.)

❒ Yes ❒ No

If yes, please list below.

____

____

Part C: About your health

11. Compared to people your own age, how would you describe your current overall state of health? (Please check (✓) one)

❒ Excellent ❒ Good ❒ Fair ❒ Poor

12. How would you rate your strength? (Please circle the number).

5	4	3	2	1
Very strong	Pretty strong	Unsure	Not very strong	Very weak

13. How would you rate your balance? (Please circle the number).

5	4	3	2	1
Very good	Good	Unsure	Not very good	Very poor

14. How would you rate your endurance? (length of time that you can keep doing exercise that you feel is stressful or takes effort) (Please circle the number).

5	4	3	2	1
Very good	Good	Unsure	Not very good	Very poor

15. Are you a regular smoker?

❒ Yes ❒ No

16. Have you ever been diagnosed by a health professional as having any of the following (Check (✓) all that apply)

- ❐ Heart Trouble
- ❐ High blood pressure
- ❐ High cholesterol
- ❐ Osteoporosis
- ❐ Arthritis
- ❐ Diabetes
- ❐ Chronic asthma
- ❐ Emphysema
- ❐ Bronchitis
- ❐ Back problems
- ❐ Foot problems
- ❐ Allergies
- ❐ Trouble hearing
- ❐ Trouble seeing

❐ Other health problems (please describe below)

____

____

____

____

17. Are you currently taking any medication for any of the conditions listed above?

❐ Yes ❐ No

If yes, please complete the “Medication List” form (available from your instructor or from the office at the Health Centre in Beachburg or Cobden)