



# Membership Form

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TITLE: \_\_\_\_\_

First name: \_\_\_\_\_ Surname: \_\_\_\_\_

Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Full Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel (home): \_\_\_\_\_ Tel (mob): \_\_\_\_\_

E-mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Concessions: *(Proof will be requested)* \_\_\_\_\_

Please tick if you are any of the following

Job Seekers	<input type="checkbox"/>	Income Support	<input type="checkbox"/>
Incapacity Benefit	<input type="checkbox"/>	Over 60 and not working	<input type="checkbox"/>
Studying for more than 16 hours per week	<input type="checkbox"/>	Under 16	<input type="checkbox"/>

Ethnic background: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Emergency contact tel: \_\_\_\_\_

***Please present proof of address***

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

## TO BE FILLED IN BY ONEKX

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PARQ Approved: Yes  No

Membership no: \_\_\_\_\_ Membership start date: \_\_\_\_\_



# Physical Activity Readiness Questionnaire

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**Name:** \_\_\_\_\_

**Membership Number:** \_\_\_\_\_

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

This questionnaire has been designed to ensure that you gain the greatest possible benefit from your membership of One KX. All members must complete before participating in any physical activity.

**Please read carefully**

If you tick any of the “Yes” boxes below you must have your doctor’s consent before you use the facilities. You will be given a doctor’s consent letter that must be signed and returned.

**Part 1 – Since last completing a PARQ at One KX:**

*Please tick the relevant boxes*

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Has your doctor said that you have a heart condition and recommended only medically supervised activity?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you have chest pain brought on by physical activity?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you developed chest pain in the past month?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you tend to lose consciousness or fall over as a result of dizziness?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has a doctor recommended medication for your blood pressure or a heart condition?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do you know through your own experience, doctor’s advice, of any other physical reason why you should not exercise without medical supervision? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Thank you for taking the time to fill in this questionnaire.

**FOR OFFICE USE ONLY**

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PARQ Approved by: \_\_\_\_\_

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

*Please be aware that only members of staff with a current qualification in exercise and fitness knowledge are able to approve PARQ forms.*