Exercise Pre-Screening Questionnaire

Shire of Coolgardie
Mother of the Goldfields

This is to be completed in preparation for physical activity. It is important that you disclose ALL, of your existing medical conditions so that we/I may determine whether to seek further medical advice, before commencing an exercise program. This questionnaire does not provide medical advice, in any, form and does not substitute advice from appropriately qualified professionals.

Name: _____ Surname: _____

Address: _____
Postcode: _____

Contact Number: _____ DOB: ___ / ___ / ___
Age: _____ Email:_____

Emergency Contact Name: _____
Number: _____

PART ONE

Have you ever been told that you have a heart condition?
YES NO

Have you ever had a stroke? YES NO

Do you ever have unexplained pains in your chest at rest or during physical exercise? YES NO

Do you consistently feel faint or suffer from spells of dizziness?
YES NO

Do you suffer from asthma and require medication?
YES NO

Do you suffer from type I or II diabetes?
YES NO

Do you suffer from any major muscle or joint conditions that may limit you or be aggravated by physical activity?
YES NO

Do you suffer from any medical conditions that may be made worse by participating in physical activity?
YES NO

Do you suffer from high blood pressure over 140/90 or low blood pressure below 100/80?
YES NO

DISCLAIMER:

If you have answered NO, to all the above questions and you are confident that you have no other concerns with your health, then you may proceed to participate in physical activity. If you have answered yes to any of the questions above or are unsure, please seek a referral from your GP or allied health professional before commencing physical activity.

I believe to the best of my knowledge, that the information I have provided on this tool is accurate. In the case that my medical condition changes over the course of my training I will inform my trainer and fill out a new exercise PRE-SCREENING questionnaire.

Client signature: _____ Date: ____ / ____ / ____

Trainer signature: _____ Date: ____ / ____ / ____

PART TWO

Do you have a family history of heart disease? (stroke, heart attack) YES NO

Have you been told that you have high cholesterol?
YES NO

Have you been told that you have high blood sugar?
YES NO

Have you spent time in hospital for any medical condition/illness/injury during the last 12 months?

If yes to any of the above, please give details:
_____ YES
NO

Do you smoke? If so, how many cigarettes per day/week?
_____ YES NO

Are you currently on any medication?
YES NO

If yes, what is it and for what condition? _____
_____

Are you pregnant or have you given birth in the past 12 months?
YES NO

If yes provide details on how many months and any related conditions

_____
_____

What are your top five health and fitness goals for the next 12 months?

1.

2.

3.

4.

5.

Disclaimer:

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I believe to the best of my knowledge that the information I have provided on this tool is accurate. In the case that my medical condition changes over the course of my training I will inform my trainer and fill out a new exercise PRE-SCREENING questionnaire.

Client signature: _____ Date: ____ / ____ / ____

Trainer signature: _____ Date: ____ / ____ / ____

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FITNESS ASSESSMENT TOOL

Client Name:

Date:								
Blood Pressure: Systolic								
Blood Pressure: Diastolic								
Height								
Weight								
MEASUREMENTS								
Shoulders								
Chest Waist								
(Navel) Hips								
(Mid Butt)								
	Left	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**
Thigh (Thumb)								
Arm (Flexed)								
FITNESS TESTS								
60 sec sit up								
60 sec sit and reach								
60 sec push ups								
60 sec shuttle runs								

Photo's to be taken before and after of your clients only. Fitness assessments to be completed every 3 months by appointment only.

Notes: _____