Pre- Exercise Questionnaire

Please take a few minutes to answer the following questions or work through these with an instructor. Place a **Y** to indicate **Yes** and an **N** to indicate **No** to any questions asked. This form and information will be treated as confidential and will not be released without your written consent.

Name: ________________________________ DOB: _________ Sex: _____

Address: ____

Post code: ______ Occupation: _____________________________________

Phone W: _______________________ H: ___________________

Person to be contacted in case of accident: ____________________________

Phone W: _______________________ H: ___________________

Have you ever had or do you have?

	Gout		Glandular Fever		Heart Condition
	Stroke		Heart Murmur		Diabetes
	Stomach ulcer		Raised Cholesterol		Rheumatic Fever
	Dizziness/fainting		Epilepsy		Hernia
	Liver or Kidney Condition		High blood pressure > 140/90		Palpitations or pain in chest

	Anyone in your family under 60 who has suffered heart disease, stroke, raised cholesterol or sudden death?
	Are you male over 35 or female over 45 NOT used to regular vigorous exercise?
	Are you on prescription medication?
	Have you given birth in the last 6 weeks?
	Have you been hospitalised recently?
	Are you pregnant?

If you answered yes to any of the above, please take this form to your doctor and ask for a clearance to exercise before starting any exercise program, OR sign below if you have already cleared the above condition with your doctor. Please give details of condition and related medications below.

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Condition cleared. Signature: _____________________ Date Cleared: ________
Have you ever had or do you have?

	Arthritis		Do you smoke?		Back Problems
	Asthma		Neck Problems		Ankle Problems
	Cramps		Knee Problems		
	Are you dieting?		Shoulder Problems		
	Any other conditions which may modify your exercise program?				

If you answered yes please ask the instructor for exercise class or program guidance before starting.

What exercise have you been doing recently?

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How Long (mnths/yrs):_______ Duration (mins): _______ How Often:_______

Intensity (circle) Hard Medium Light

Please read the following exercise advice carefully. Ask any staff member to guide you into the most suitable class or program. Work at a low level on your first visit and concentrate on learning to do the exercise properly. On each visit, work a little harder but limit yourself to a place where you can still talk comfortably. Should you suffer any illness, injury or condition in the future, complete this form again. **It is recommended by the American College of Sports Medicine,** that all males over 35 and females over 45 should have medical assessment including an exercise ECG, Cholesterol and lipid count.
Statement: I recognise that the instructor is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. I have answered the questions to the best of my ability and understand the advice above. *I also understand that I participate willingly and at my own risk. I understand the trainer is not liable for any injury or misadventure that may occur as a result of my participation in fitness training.*

Client Signature:	Date:
Instructors Name:	Signature:

Notes:

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