Exercise Pre-Screening Questionnaire

This is to be completed in preparation for physical activity. It is important that you disclose ALL of you 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.

Title:_____ Name:_____Surname:_____
Address: _____Postcode:_____
Contact Number: _____DOB:_____Age:___Email:_____
Emergency Contact Name:_____Number:_____

	Yes	No
Part One: Have you ever been told that you have a heart condition?		
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 of 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 all of 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:_____Trainer signature:_____
Date:_____ Date:_____

Part Two (Optional)

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?	Yes	No

If yes to any of the above, please give details:

_____

Do you smoke? If so how many cigarettes per day/week?

_____

_____

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?

_____

_____

_____

_____

_____

_____

_____

_____

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Client signature:_____ Trainer signature:_____

Date:_____ Date:_____

Fitness Assessment Tool

Client Name:												
Date:												
Blood Pressure:												
Weight												
Measurements												
Shoulders												
Chest												
Waist (Navel)												
Hips (Mid Butt)												
	Left	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**
Thigh (Thumb)												
Arm (Flexed)												
Fitness Test (Optional)												
60 second squats												
60 second push ups												
60 second shuttle runs												

It is also a good idea to do before and after photos of your clients only if this is something that they are comfortable doing.

Notes:_____

_____