



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.

Name: _____ Surname: _____

Contact Number: _____ DOB: _____ Age: _____

Email: _____

Emergency Contact Name: _____ Number: _____

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|---|-----|----|
| Have you ever been told that you have a heart condition/or 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 |
| Have you been told you have high blood pressure, are you on medication? | Yes | No |
| 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 | Yes | No |
| Do you smoke? If so how many cigarettes per day/week? <input type="checkbox"/> | 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 6 months? | 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: _____