Must be completed and handed in before beginning classes Wellness Centre Wollongong NSW 02 42263777

Pre-Exercise Questionnaire

Please take a few minutes to answer the following questions or work through these with staff. Place a ✓ to indicate "Yes or Not Sure" and a ✗ to indicate "No". The information contained will be treated as confidential and will not be released or revealed without your written consent.

Name:_____ Age:_____ Sex:_____ Occupation/Employer_____

Address:_____ Suburb_____ Postcode:_____

Email: _____ Phone: H:_____ Mobile:_____

Person to be contacted in case of accident:_____ Phone:H_____ W_____

Have you ever had or do you have?

- ☐ Anyone in you family under 60 who has suffered Heart Disease, stroke, raised cholesterol or sudden death?
- ☐ Are you Male over 35 or Female over45 and **NOT** used to regular exercise?
- ☐ Are you on prescription medication?
- ☐ Have you been hospitalized recently?
- ☐ Have you given birth in the last 6 weeks?
- ☐ Are you pregnant?

Do you have or have you had:

- ☐ Gout
- ☐ Glandular Fever
- ☐ Dizziness or fainting
- ☐ Any Heart Condition
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart murmur
- ☐ High blood pressure ≥ 140/90
- ☐ Epilepsy
- ☐ Stomach or duodenal ulcer
- ☐ Palpitations or pain in the chest
- ☐ Raised cholesterol/triglycerides
- ☐ Hernia
- ☐ Liver or kidney condition
- ☐ Rheumatic fever

If you "✓" 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 you doctor. Please give details of condition and related medications on the reverse side of this form.

Condition cleared. Signature_____ Date cleared _____

Have you ever had or do you have:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cramps
- ☐ Are you dieting or fasting
- ☐ Do you smoke?

Any pain or major injuries in the following areas?

- ☐ Neck
- ☐ Knees
- ☐ Shoulders
- ☐ Back
- ☐ Ankles
- ☐ Any muscular pain?

☐ Are there any other conditions which may be reason to modify your exercise program?

If you "✓" any of the above please ask Elizabeth for exercise class or program guidance before starting

What exercise have you been doing recently _____

Exercise type:_____ How long?(mths/years)_____ How often?_____

Intensity? (circle) Hard Medium Light

PLEASE READ THE FOLLOWING EXERCISE ADVICE CAREFULLY. Ask Elizabeth 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 pace where you can still talk comfortably. Should you suffer any illness, injury or condition in the future, please 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 a medical assessment including an exercise E.C.G., cholesterol and lipid count.

STATEMENT: I recognize 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.

Client Signature:_____ Date:_____

Instructors Name: Checked:_____