

# Pre-Exercise Questionnaire

Please take a few minutes to answer the following questions or work through these with Elizabeth. 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: \_\_\_\_\_ W: \_\_\_\_\_

Person to be contacted in case of accident: \_\_\_\_\_ Phone: H \_\_\_\_\_ W \_\_\_\_\_

Have you ever had or do you have?

- 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 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Gout                  | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Palpitations or pain in the chest |
| <input type="checkbox"/> Glandular Fever       | <input type="checkbox"/> Heart murmur                 | <input type="checkbox"/> Raised cholesterol/triglycerides  |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> High blood pressure ≥ 140/90 | <input type="checkbox"/> Hernia                            |
| <input type="checkbox"/> Any Heart Condition   | <input type="checkbox"/> Epilepsy                     | <input type="checkbox"/> Liver or kidney condition         |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Stomach or duodenal ulcer    | <input type="checkbox"/> 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 your 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  Cramps  Do you smoke?
- Asthma  Are you dieting or fasting

Any pain or major injuries in the following areas?

- Neck  Shoulders  Ankles
- Knees  Back  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: Elizabeth Jarvis**

**Checked:** \_\_\_\_\_