PRE-EXERCISE / LIFESTYLE SCREENING QUESTIONNAIRE

Please take a few minutes to answer the following questions.

Name: _____ DOB: _____ Age: _____ Sex: M / F

Mobile Phone Number: _____

Email: _____

Address: _____ Post Code: _____

Emergency Contact Name: _____ Tel No: _____

Previous Exercise: (Briefly Outline).

It is our professional duty of care to ask all participants, no matter what age, to complete the following
Simply place ✓ to indicate Yes.

Have you been hospitalised recently?	o
Are you pregnant?	o
Have you given birth in the last 6 weeks?	o

Do you have or have you had:

Diabetes	o	Dizziness or Fainting	o	High Blood Pressure (over 140/90)	o
Epilepsy	o	Stomach/Duodenal Ulcer	o	Palpitations or Pains in the Chest	o
Hernia	o	Liver or Kidney Condition	o	Any Heart Condition	o
Asthma	o	Stroke	o	Muscular Pain	o
Arthritis	o	Shortness of breath	o	Pain in Neck, Knees, Back or Ankles	o

If yes give details:

_____

_____

_____

Is there anything in your medical history you feel could affect your ability to exercise?

Are you taking any medication? Give Details:

I can confirm that I have had the all clear by my GP to commence suitable exercise. I am aware that I must feel well prior to each class and will notify you (the trainer) should I feel unwell at any time during the class. Whilst I am aware that every effort has been taken to ensure this exercise class is suitable for everyone. I understand that my participation and safety are my responsibility.

Signed Date: