

PRE-EXERCISE QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Mobile Number: _____ Home Phone Number: _____

Email Address: _____

Emergency Contact Person & Contact Number: _____

Lifestyle and Medical Information

Have you had a recent medical check up? _____

Are you currently on any medication? If Yes what is it and what is it for? _____

Are you currently pregnant or have recently given birth? _____

Are you a smoker or ever smoked? _____ Weekly alcohol consumption? _____

Have you ever had surgery? If Yes, when and what for? _____

Do you have any physical conditions or movement restrictions that may affect your training? _____

If Yes, are you seeing a physician or health professional? Who? _____

Have you been advised by a health professional to undertake an exercise program? _____

If Yes, have you been advised to **avoid** or **include** any particular exercise? _____

Medical Condition	Yes	Medical Condition	Yes	Medical Condition	Yes
Asthma		High Cholesterol		Vestibular Problems	
Arthritis		Kidney Problems		Any Neuromuscular Disease	
Diabetes		Heart Attack		Swollen Joints	
Migraine		Stroke		Broken Bone/Dislocated Joint	
Light Headedness/Dizziness		Chest Pains		Muscular Injury [Strain]	
High/Low Blood Pressure		Respiratory Disorders		Back/Neck Injury or Pain	

Other than previously stated, is there anything else you can think of that may affect your training in any way? _____

I declare that I have provided all information relevant to any medical conditions I am aware of that may or may not affect undertaking exercise and/or an exercise program.

Date: _____ Trainer: _____

Signed: _____