PRE-EXERCISE QUESTIONAIRE

Please take a few minutes to answer the following questions

Your Details

Name	
DOB - Age	
Sex – Male/Female	
Home Telephone	
Mobile Telephone	
Email Address	
Emergency Contact Name & Number	

Medical Considerations

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

Has a family member, under 60, suffered from heart disease, stroke, raised cholesterol or sudden death? ❑
Are you on any prescribed medication?..❑
Have you been hospitalised recently?..❑
Are you pregnant?..❑
Have you given birth in the last 6 weeks?..❑
Do you have any infections or infectious diseases?..❑

Do you have or have you had any of the following: -

Gout	❑	Glandular Fever	❑	Any Heart condition	❑
Stroke	❑	Rheumatic Fever	❑	Heart Murmur	❑
Diabetes	❑	Dizziness or fainting	❑	High Blood Pressure (over 140/90)	❑
Epilepsy	❑	Stomach/Duodenal Ulcer	❑	Palpitations or Pains in the Chest	❑
Hernia	❑	Liver or Kidney Condition	❑	Raised Cholesterol/Triglycerides	❑
Asthma	❑	Arthritis	❑	Muscular Pain	❑
Cramps	❑				

Do you have any Pain or Major injuries in the following areas:-

Neck...............❑ Knees................❑ Back.................❑ Ankles....................❑

Please give details of any conditions: -
If you have ticked any of the above, you need a signed medical clearance from your doctor before starting exercise. Doctors clearance: **Or** **I warrant that I am physically and mentally well enough to proceed with usage of the facility.** **Clients self-clearance of the above conditions:** ______________________________ Date:________________