PRE-EXERCISE QUESTIONNAIRE

NAME: ____**DOB :** _____________

ADDRESS: ____

____ **POSTCODE:** _________________

PH HOME:______________________________

PH WORK: _____________________________

MOBILE: ______________________________

EMAIL: ____

Please indicate with a √ your preferred method of communication

HOW DID YOU HEAR ABOUT US? ____

EMERGENCY CONTACT:
NAME & PHONE: ____

The information obtained from this questionnaire will help us build a profile of your current health and fitness status. This will enable the exercise specialist to design an appropriate exercise program for you. All information in this questionnaire will be treated as **private** and **confidential.**

OFFICE USE ONLY:

EP □ **WC** □ **PT** □ **GTS** □

INITIAL CONSULATION DATE: ______________________________

CONDUCTED BY: __________________________________

- *This questionnaire will ask you some questions related to your current state of health, fitness and wellbeing.*
- *These questions will cover different areas of life and are designed to help focus and prioritise what is important to you.*

MEDICAL HISTORY

	Yes *(details)*	No
1. Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke?		
2. Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?		
3. Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?		
4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?		
5. If you have diabetes (type I or type II) have you had trouble controlling your blood glucose in the last 3 months?		
6. Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?		
7. Do you ever experience feelings of anxiety or depression?		
8. Have you been hospitalized for any reason in the past 12 months?		
9. Are you pregnant or have given birth in the past 12 months?		
10. Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise?		

- Name of General Practitioner: ____
- Practice address: ____
- Date of last medical and physical examination: ______________________________

ENERGY

How do you rate your current energy levels?

1 2 3 4 5 6 7 8 9 10
low *high*

How important is it that you make changes or improvements in your energy levels?

1 2 3 4 5 6 7 8 9 10
not important *very important*

On average, how many hours sleep do you have each day?__________________
What is your occupation?____
How many hours do you work per week? _________________________________
Do you have any stress management techniques? (If yes, *please specify)*_____________________________

EXERCISE

How do you rate your current overall fitness?

1 2 3 4 5 6 7 8 9 10
poor *excellent*

How do you rate each area of your fitness?

Aerobic fitness
1 2 3 4 5 6 7 8 9 10
low/poor *high/excellent*

Strength
1 2 3 4 5 6 7 8 9 10
low/poor *high/excellent*

Flexibility
1 2 3 4 5 6 7 8 9 10
low/poor *high/excellent*

Which area/s of fitness are most important for you to make changes or improvements?

____

Have you had any negative experiences with exercise programs?__________________________________
____

NUTRITION

How do you rate your current dietary habits?

1 2 3 4 5 6 7 8 9 10
poor *excellent*

- I eat 5 serves of vegetables & 2 serves of fruit a day: Often / Sometimes / Rarely / Never
- I drink 8 glasses of water a day: Often / Sometimes / Rarely / Never
- I eat out/get take-way foods: Daily / Once weekly / Fortnightly / Rarely
- I eat the following meals most days: Breakfast / Morning tea / Lunch / Afternoon tea / Dinner / Dessert

Is there any other information that has been omitted from this questionnaire that you feel is important in helping you towards your fitness goals.

____

____

____

It is recommended that all males over 35 and females over 45 should have a medical assessment including an exercise ECG and cholesterol/Lipid count.

STATEMENT

I recognise that the Consultant 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.

I will also inform the Consultant of any injury, illness or condition that occurs in the future.

Signed:____

Date:____________________