Complete form and email to:
powertoyoufitness@yahoo.com.au

Pre-Exercise Questionnaire

Please take a few minutes to answer the following questions or work through these with an instructor. Place a ✓ to indicate "Yes or Not Sure" and a ✗ to indicate "No". This form and information will be treated as confidential and will not be released without your written consent.

Name:____ DOB:_______________ Sex:_________
Address: ____ P'code:______________
Occupation: __________________________Phone: W _____________________M __________________
Emergency contact person:____
Emergency contact phone: W: ___________________________ M________________________________

Have you ever had or do you have?

- ❑ Anyone in your family under 60 who has suffered Heart Disease, Stroke or Raised Cholesterol?
- ❑ Are you male over 45 or female over 55 and **NOT** used to regular vigorous exercise?
- ❑ Are you on prescription medication?
- ❑ Have you been hospitalised recently?
- ❑ Have you given birth in the last six weeks?
- ❑ Are you pregnant?

Do you have or have you had:

- ❑ Arthritis
- ❑ Asthma
- ❑ Stroke
- ❑ Dizziness or Fainting
- ❑ Stomach or Duodenal Ulcer
- ❑ Liver or Kidney Condition
- ❑ Glandular Fever
- ❑ Heart Murmur
- ❑ High Blood Pressure $\geq$ 140/90
- ❑ Palpitations or Pain in Chest
- ❑ Raised Cholesterol/Triglycerides
- ❑ Any heart condition
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Hernia
- ❑ 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 ?

Any pain or major injuries in the following areas:

- ❑ Neck
- ❑ Knees
- ❑ Shoulders
- ❑ Back
- ❑ Ankles
- ❑ Other
- ❑ Any muscular pain
- ❑ Cramps
- ❑ Are you dieting or fasting?
- ❑ Do you smoke?
- ❑ Are there any other conditions which may be reason to modify your exercise program ?

If you ✓ any of the above, please ask instructor for exercise class or program guidance before starting.

What exercise have you been doing recently? ____

How long (months/years):______________ Duration (mins):______________ How often:______________

Intensity (please circle) Hard Medium Light

PLEASE READ THE FOLLOWING EXERCISE ADVICE CAREFULLY. Ask any staff member 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 you will be able to work a little harder. Be sure to limit yourself to a pace where you can still talk comfortably. Should you suffer any illness, injury or condition in the future, please tell us by completing this form again.

STATEMENT: I recognise 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. I agree to have photos taken and used for promotional purposes.

Client Signature:____ Date:______________________

Instructor's Name: Fiona Demetriou______________________ Signature:__________________