Pre – Exercise Questionnaire

Name:	Age:	Birthday:
Telephone / Mobile :	Sex: M / F	Email:
Occupation:	Children: Y / N	Ages:
How many times are you exercising p/w?	Length of Time:	Which are you? Beginner / Intermediate / Advanced
How much to you enjoy exercising? Scale 1-10	How would you rate your fitness levels? Scale 1-10	

Training Goals / Motivation

Training Goals: (eg: Lose 5kg, fitness) • • • • •	Focus Areas (eg: Arms / Hips) • • • • •	What difference will these goals make to your life?
Where are you to achieving these goals? Scale of 1-10		Any set time frame?
How important is it to you to achieve these goals? Scale of 1-10		How many times a week are you prepared to exercise? With me? By self?

Exercise History

What exercise / activity are you currently doing (including sports)? • • • •		
How often a week would you use weights?	I find I get bored easily with exercise. Yes / No	
I like my workouts to be: Structured / Random	Have you done any of the following classes? Pump / Spin / Yoga / Water aerobics / Body combat / Pilates / Other	
What do you want from me and our sessions? • • • •		On a scale of 1-10 how hard do you want to be pushed in our sessions?

Diet

How would you describe your diet / eating habits?	What is your biggest eating weakness?	How many units of alcohol would you consume a week?

Other:

Pre – Exercise Questionnaire

Medical

General Health (Y or N)	Do you suffer or have you suffered from any of the following:	(Y or N)
☐ Has anyone in your family under 60 suffered from a Heart Disease, Stroke, High Cholesterol or Sudden Death?	☐ Glandular Fever	☐ High Blood Pressure
☐ Are you male over 35 or female over 45 and NOT used to regular vigorous exercise?	☐ Stroke	☐ Low Blood Pressure
☐ Are you on any prescribed medication	☐ Diabetes	☐ Tightness in chest
☐ Have you given birth within the last 6 weeks?	☐ Epilepsy	☐ Any Heart Condition
☐ Do you suffer from any infectious disease	☐ Asthma	☐ Raised Cholesterol
☐ Have you been hospitalized recently	☐ Hernia	☐ Stomach Ulcer
☐ Are you pregnant?	☐ Arthritis	☐ Miscarriage in the last 6 months
	☐ Dizziness or Fainting	

Have you had a baby in the last 12 mths? Y / N	C-section: Y/ N	Do you have medical clearance to exercise? Y / N
Do you smoke? Yes / No	What intensity have you been working out at recently? ☐ Hard ☐ Medium ☐ Light	

Do you have any joint injuries or weaknesses particularly in the following areas (Please tick):

☐Lower Back ☐Neck ☐ Ankle ☐ Knee ☐Hip ☐Shoulder ☐ Wrists ☐Other:

Which side? Left / Right Please explain briefly:……..

Do you have any other medical problems / conditions I should know about, or issues that would limit your exercising / training?

Are you on any medication?

Do you regularly see any of the following: ☐Physiopharist ☐ Masseur ☐Chiropractor

What area to they treat:

I get neck pain when doing crunches or sit ups ☐ Yes ☐ No . **If YES** does supporting your neck help? ☐ Yes ☐ No

Other information I feel you should know before I start an exercise programme :

Please read the below statement and then sign and date

Statement: My signature is an acknowledgement that I am physically capable and there is no medical reason to prevent me from proceeding with exercising without endangering my health. I recognise my personal trainer is not able to provide me with medical advice about my fitness & health, and that this information sheet is used as a guideline to the limitations of my ability to exercise. I have answered the questions to the best of my ability. I am aware that any physical activity can be hazardous and that there is a risk involved.

Should I suffer any injury, illness or condition in the future I will advise my trainer before I begin exercising and complete an updated form.

Client Signature:	**EMERGENCY CONTACT**
Name:……	Name:……
Signature:…….	Relationship:…….
Date:……	Contact:……

Additional Notes:

Follow Up: