Pre-Exercise Questionnaire Form

In preparation for physical activity, please tell us about ALL of your existing medical and physical conditions, and who to contact in an emergency. It is your responsibility to complete this form before participating in any physical activity. For any conditions that can be affected by exercise, you may be asked to consult your doctor and obtain a written medical clearance to exercise. Please give this clearance to your instructor. This information contained will be treated as confidential and only revealed to relevant persons such as health professionals for your safety.

Please note that it is your responsibility to inform us of any changes in your medical or physical condition during your training with Lynne Scott.

PERSONAL DETAILS

Name: ……Age: .....DOB: ...../...../..... M / F

Address: ……

Phone Home: …..…… Mobile: …….. Email:……

Emergency Contact Person 1:…….. Phone:……

Emergency Contact Person 2:…….. Phone:……

Email:…….

1. Do you have, or have you had:

- ❑ High blood pressure
- ❑ Do you smoke
- ❑ Osteoporosis
- ❑ Epilepsy
- ❑ Stroke
- ❑ Chest pain
- ❑ Pain/tightness in chest
- ❑ Chronic cough
- ❑ Gout
- ❑ Dizziness
- ❑ High cholesterol
- ❑ Rheumatic fever
- ❑ Lower back pain
- ❑ Stomach/ulcer
- ❑ Liver/kidney condition
- ❑ Hernia
- ❑ Cramps
- ❑ Muscular pain
- ❑ Arthritis/joint pain
- ❑ Stress/anxiety
- ❑ Circulation problems
- ❑ Depression
- ❑ Dementia
- ❑ Hysterectomy
- ❑ Problems with pelvic floor
- ❑ Neuropsychology
- ❑ Cancer
- ❑ Any stomach operations
- ❑ Fusions feet or spine
- ❑ One or two kidneys ……

- ❑ Plates: Please describe where?

……

……

- ❑ Heart disease (please specify):

……

……

- ❑ Any other conditions? Please describe

……

……

……

- ❑ No or none of the above.

2. **How long since your last medical check up?**

……

...……

3. **Are you taking any prescribed medication?**
YES/NO. If, yes please llist

……

...……

4. **Has any of your immediate family suffered Heart Disease?** YES/NO. If, yes which relative and what age?

……

……

5. **Do you have, or had, any joint problems,pains or injuries in any of the following regions?**

- ❑ Ankles/feet
- ❑ Shoulders
- ❑ Muscular Pain
- ❑ Knees
- ❑ Neck
- ❑ Hip/pelvis
- ❑ Elbows
- ❑ Lower Back
- ❑ Wrist
- ❑ Other? Please describe below

……

……

6. **Are you currently taking any medication/s?**
Please describe

……

……

7. **Are you, or have you recently been pregnant?** YES/NO

Please state when your last pregnancy was

……

...……

8. **Do you smoke? How many per day or week?**

……

...……

9. **Goals and objectives:**
What do you want to achieve from your exercise programme?

……

……

……

……

10. **Have you visited a Physiotherapist, Chiropracter, Osteopath if so when?**

……

……

11. **Are you currently exercising?**

YES/NO. If so, please state what type?

……

……

...……

How hard? □ Easy/light □ Moderate □ High

How may times per week?

……

Have you exercised in the past? YES/NO.
If so when?

……

……

12. What activities do you currently participate in?

……

……

13. Do you consider your diet to be:

☐ Good ☐ Adequate/appropriate ☐ Poor

14. How do you rate you stress level?

☐ High ☐ Moderate ☐ Low

☐ I understand that I may participate in physical activities wich may expose me to certain risks and that I do so at my own risk.

I will not hold Lynne Scott responsible, or any of Body Tonic Group staff or agents liable for any injury, loss, damage or death caused to me or my property, whether by negligence omission, and breach of contract or in any way whatsoever.

I …… (full name), undertake to complete a pre-activity questionnaire in the event of training with Lynne Scott.
Any change in my medical status during the course of being associated and training with Lynne Scott, I understand that it is my responsibility to advise Lynne Scott of any medical or physical conditions that may prevent me from exercising, and that I participate in exercie at my own risk.

I …… (full name), understand that outside of training sessions with Lynne Scott, I accept that I exercise at my own risk and that Lynne Scott or any of her associates is not Liable, for any injuries, and that I participate in exercise at my own risk.

Signature: _____(Parent/Guardian to sign if under 18 years of age)

Full name (please print):_____Date: _____

Full name of child (please print):_____Date: _____

Name of Instructor:_____

Signature of Instructor: _____

Date: _____

This is not a doctors screening, for advice from an appropriately medical professional, please see your family health doctor. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by The Body Tonic Group for any loss, damage or injury that may arise from any person acting on any statement or information contained in this tool.

AIM:

To identify individuals with a known disease, or signs or symptoms of disease, who may be at a higher risk of an adverse event during physical activity/exercise? This stage is self-administered and self-evaluated.

		Please circle response	
1.	Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?.	Yes	No
2.	Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?.	Yes	No
3.	Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?.	Yes	No
4.	If you have diabetes (Type I or Type II) have you had trouble controlling your blood glucose in the last 3 months?.	Yes	No
5.	Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical.	Yes	No
6.	Activity/exercise? Do you have any other medical condition(s) that may make it a more serious health concern for you, when you participate in physical activity/exercise?	Yes	No

IF YOU ANSWERED 'YES' to any of the questions, please seek guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise.

If you are exercising, please explain what happens? Such as, do you get excessively thirsty? Do you get out of breath? Or lose your breath quickly? Do you feel nauseous or have any other symptoms Lynne Scott needs to know to ensure your safe training? Please answer below to help ensure your progress and safety.

_____

_____

_____

_____

- ❑ I believe and to the best of my knowledge that this screening questionnaire/tool I have answered is true and correct, and I have answered all questions to the best of my knowledge, all of the information I have supplied within this tool is correct with my health condition and fitness level.

Signature: _____(Parent/Guardian to sign if under 18 years of age)

Full name (please print):_____Date: _____

Full name of child (please print):_____Date: _____

Name of Instructor:_____

Signature of Instructor: _____

Date: _____

EXERCISE INTENSITY GUIDELINES

Please tick which box and level you think you are at with exercise. If you don't do exercise this is N/A

INTENSITY CATEGORY	PLEASE TICK RATING	PERCEIVED EXERTION MEASURES	DESCRIPTIVE MEASURES
SEDENTARY	1-10 Rating 1: Good 10: Bad _____	Very, very light RPE# < 1	• Activities that usually involve sitting or lying and that have little additional movement and a low energy requirement
LIGHT	1-10 Rating 1: Good 10: Bad _____	Very light to light RPE# 1-2	• An aerobic activity that does not cause a noticeable change in breathing rate • An intensity that can be sustained for at least 60 minutes
MODERATE	1-10 Rating 1: Good 10: Bad _____	Moderate to somewhat hard RPE# 3-4	• An aerobic activity that is able to be conducted whilst maintaining a conversation uninterrupted • An intensity that may last between 30 and 60 minutes
VIGOROUS	1-10 Rating 1: Good 10: Bad _____	Hard RPE# 5-6	• An aerobic activity in which a conversation generally cannot Be maintained uninterrupted • An intensity that may last up to about 30 minutes
HIGH		Very hard RPE# ≥ 7	• An intensity that generally cannot be sustained for longer than about 10 minutes

Outdoor Training Pre Exercise & Screening Form

To accompany the Pre-exercise Screening Questionnaire

Your name:_____Today's date: _____

Emergency contact name:_____Phone number: _____

What do you like?

Tick the outdoor environments that you prefer to train in.

- ❒ Parks (trees and grass)
- ❒ Sporting fields
- ❒ Bushland/forests
- ❒ Beach – grassed areas
- ❒ Near rivers/lakes/harbor's
- ❒ Urban (buildings/roads)
- ❒ Beach – sand and water
- ❒ Countryside/national parks
- ❒ Other – please describe below

Tick how you would prefer to participate in outdoor personal training.

❒One-on-one ❒With one other client ❒Small groups ❒Large groups

What times would you prefer to train outdoors? (please tick)

❒Early morning ❒Mid morning ❒Lunch-time ❒Afternoon ❒After work/evening

What are the benefits of the outdoor training environment for you?

_____

_____

Please write what activities do you like to do outdoors that could be used in your training sessions?

_____

_____

You and the 'Great Outdoors'

Do you have any concerns or phobias about training in the outdoor environment?

_____

_____

_____

_____

Do you or have you experienced any of the following:

❑ Allergies to grass/pollen/pollution ❒ Reaction to insect bites ❒ Heat exhaustion/stroke

❒ Stress incontinence in activities such as jumping? ❒ Anxiety about exercising in public areas

❒ Are there any other conditions which may be of reason to modify your exercise program?

If yes, please describe _____

_____

_____

❒ I understand that this questionnaire is to be completed in conjunction with a Pre-Exercise Questionnaire.

Signature: _____(Parent/ Guardian to sign if under 18 years of age)

Full name (please print):_____Date: _____

Name of Instructor:_____

Signature of Instructor: _____