

PRE-EXERCISE QUESTIONNAIRE

This screening tool does not provide advice on a particular matter, nor does it substitute for advice from an appropriately qualified medical professional. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Fitness First or its employees/agents/contractors/franchisees for any loss, damage or injury that may arise from any person acting on any statement or information contained in this tool.

NAME: _____ **AGE:** _____
DATE OF BIRTH: _____ **MOBILE:** _____
EMAIL: _____
ADDRESS: _____
SUBURB: _____ **POSTCODE:** _____
EMERGENCY CONTACT: _____

1. Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?	YES	NO
2. Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?	YES	NO
3. Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	YES	NO
4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	YES	NO
5. If you have diabetes (type I or type II) have you had trouble controlling your blood sugar (glucose) in the last 3 months?	YES	NO
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?	YES	NO
7. Do you have any other conditions that may require special consideration for you to exercise?	YES	NO

IF YOU ANSWERED YES to any of the 7 questions, please seek guidance from an appropriate **ALLIED HEALTH PROFESSIONAL OR MEDICAL PRACTITIONER** prior to undertaking exercise.

OR I acknowledge that I am currently under the supervision of a medical practitioner who has approved my participation in an exercise program.

Please tick **Signature:** _____

ALL NO ANSWERS. IF YOU ANSWERED 'NO' to all of the 7 questions, and you have no other concerns about your health, you may proceed to undertake light-moderate intensity physical activity/exercise.

I believe that to the best of my knowledge all of the information I have supplied is correct.

SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PUTTING YOURSELF FIRST

ON AN AVERAGE DAY, HOW MANY PEOPLE COUNT ON YOU?

.....

WHAT ARE THE THINGS YOU DO FOR OTHERS?

.....

.....

.....

.....

.....

.....

WHAT ARE THE THINGS YOU DO FOR YOURSELF?

.....

.....

.....

.....

.....

.....

WHAT'S THE DATE YOU WOULD LIKE TO START PUTTING YOURSELF FIRST?

.....

HOW MANY TIMES A WEEK DO YOU PLAN TO PUT YOURSELF FIRST?

.....