



PRE-SCREENING QUESTIONNAIRE.

PERSONAL PARTICULARS

TITLE NAME SURNAME D.O.B. AGE

HOME PH MOBILE PH WORK PH

ADDRESS SUBURB POST CODE

OCCUPATION EMAIL

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT FOR YOU?

NAME RELATIONSHIP

HOME PH MOBILE PH WORK PH

MEDICAL HISTORY TICK IF YES CROSS IF NO

Q1. HAVE YOU CONSULTED A DOCTOR ABOUT STARTING AN EXERCISE PROGRAM? YES..... NO.....

Q2. HAVE YOU KNOWINGLY SUFFERED FROM?	HEART CONDITION	HIGH CHOLESTEROL
	ARTHRITIS	MAJOR OPERATIONS
	ASTHMA	ANY MAJOR INJURIES
	DIABETES	PAIN OR TIGHTNES IN CHEST
	EPILEPSY	HEART PALPITATIONS
	REGULAR HEADACHES	ANY INFECTIONS OR INFECTIOUS DISEASES?
	CANCER	LIVER / KIDNEY CONDITION
	THYROID CONDITION	HIGH / LOW BLOOD PRESSURE
	ARE YOU PREGNANT?	HAVE YOU BEEN HOSPITALISED LATELY?
	MUSCULAR PAIN OR CRAMPS	FEMALE >45 YRS & UNACCUSTOMED TO EXERCISE?
	HERNIA	MALE >45 YRS & UNACCUSTOMED TO EXERCISE?
	BACK PAIN	RHEUMATIC FEVER
	CHRONIC COUGH	ANY CONDITION THAT MAY LIMIT YOUR ACTIVITY?

Q3. DO YOU REGULARLY SMOKE? YES..... NO.....

Q4. IF YOU HAVE TICKED OR ANSWERED YES TO ANY OF THE ABOVE, OR HAVE ANY OTHER CONDITION PLEASE PROVIDE DETAILS:

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Q5. ARE YOU TAKING ANY NON PRESCRIBED OR PRESCRIBED MEDICATIONS?YES NO
IF YES, PLEASE PROVIDE DETAILS:

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DO YOU EXPERIENCE ANY SIDE EFFECTS FROM THESE MEDICATIONS?

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND HAVE COMPLETED THIS SECTION TO THE BEST OF MY KNOWLEDGE

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SIGN DATE