



Pre-Exercise Questionnaire

Please take a few minutes to answer the following questions.

Full Name _____ DOB _____ Male | Female
 Address _____ Postcode _____
 Email _____ Mobile _____
 Occupation _____
 Emergency Contact:
 Name _____ Mobile _____

Anything important we need to know?

(Please tick boxes for 'yes' or we will assume you mean 'no')

Do you suffer from:	Yes	Do you experience, or have you experienced:	Yes	Misc:	Yes
Heart Condition		Pain or tightness in the chest		Are you pregnant?	
Family History of Heart Disease or Stroke		Heart palpitations		Any condition that may limit your exercise activity?	
Arthritis		Rheumatic Fever		Are you male >=35 yrs & unaccustomed to exercise?	
Asthma		Liver / Kidney conditions		Are you female >=45 yrs & unaccustomed to exercise?	
Diabetes		Regular Headaches		Do you suffer from pain in your:	
Pre-diabetes		Have you been hospitalised lately?		Neck	
Epilepsy		Any major injuries		Shoulders	
High Blood Pressure		Any Infections or Infectious Diseases		Back	
Low Blood Pressure		Muscular Pain or Cramps		Knees	
Other (please specify):		Hernia		Ankles	
		Back pain		Other (please specify):	
Are you on medication for blood pressure, diabetes or cholesterol?		Chronic cough			
Are you on other medication?		High Cholesterol			
If you have answered 'Yes' to any questions about your health, have you had clearance from your Doctor to exercise?					

I, _____ acknowledge that Healthquarters recommends clearance should be obtained from a Doctor prior to participating in an exercise program. Should I not receive this clearance, I agree I am doing so at my own risk.

I, _____ recognise that undertaking in exercise activity may be physically demanding and challenging. I agree that in participating in exercise activity, I assume the risks associated with this, and that no liability for death, disorder, injury or health condition made be made against Healthquarters.

Name: _____

Signature: _____ Date: _____