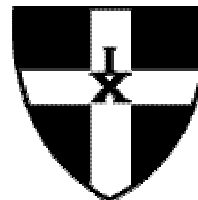


Pre-Exercise Questionnaire



Full Name:

Membership No:

The questionnaire has been designed to ensure that you begin activity at The King's School Recreation Centre Fitness Suite quickly and safely.

Please complete by ticking the relevant boxes.

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition and/or have you been recommended for medically supervised activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you have chest pain brought on by physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you suffer from dizziness or fainting? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have a joint problem that could be aggravated by physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Are you a diabetic? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has a doctor ever recommended medication for your blood pressure or a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you suffer from breathlessness after slight exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you over 65 and unaccustomed to regular physical exercise? |

If you have answered yes to any of the above questions, please contact your GP following your gym induction to get written consent that you are in suitable physical condition to undergo regular exercise.

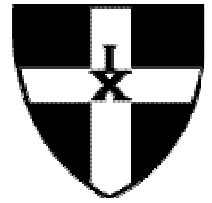
- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you have a family history of heart disease in parents or siblings below the age of 65? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you currently pregnant or have you had a baby in the last six months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Is there any other reason why you should not partake in regular physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have high/raised blood pressure (hypertension)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you suffer from Epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you exercise regularly? If yes, how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you currently smoke? If yes, how many do you smoke? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you have a high cholesterol level? Don't know |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you currently taking any prescribed medication? If so, what? _____ |

Please mark below which goals you would like to achieve

- | | |
|--|--|
| <input type="checkbox"/> Reduce body fat | <input type="checkbox"/> Muscular size |
| <input type="checkbox"/> Stop smoking | <input type="checkbox"/> Look better |
| <input type="checkbox"/> Feel better | <input type="checkbox"/> Reduce back pain |
| <input type="checkbox"/> General Fitness | <input type="checkbox"/> Improve diet |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Aerobic fitness |
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Muscular strength |
| <input type="checkbox"/> Injury rehabilitation (state injury type) _____ | |
| <input type="checkbox"/> Sports specific goals (state your sport) _____ | |

Pre-Exercise Questionnaire continue overleaf...

Pre-Exercise Questionnaire continued...



Full Name:
Date of Birth:
Address:

Telephone No:
E-Mail Address:

Emergency No:

G.P. Name:

G.P. Address

G.P. Tel No:

Statement

I recognise that the instructor is not able to provide me with medical advice with regard to my medical fitness and that the above information is used only as a guideline to the limitations of my ability to exercise.

Signed:

Date:

Signed on behalf of
The King's School
Recreation Centre

Date: