

## True Vitality Pre-Exercise Questionnaire

It is important that you consider your health before you embark on an exercise programme. If you are in any doubt about your current health, or how vulnerable you are to injury, please seek medical advice before commencing.

Please answer the following questions in order that we may both feel safe should anything happen during the class. Please note that all information will be kept confidential.

Name : ..... Age : ..... DOB : ..... Sex : .....

Address : .....

..... Post Code : .....

Contact Nos. : ..... Email : .....

Occupation : .....

In case of emergency: Name : ..... Contact No. : .....

**Please tick:**

	Y	N
Have you ever suffered from any form of heart complaint?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family under 60 suffered from heart disease, stroke, raised cholesterol or sudden death?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on any prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a male over 35 or a female over 45 and <b>NOT</b> used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you given birth within the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalised recently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any infections or infectious diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dieting or fasting?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any other conditions that might affect your ability to exercise?	<input type="checkbox"/>	<input type="checkbox"/>

**Do you have or have you ever had:**

Arthritis	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Dizziness or Fainting	<input type="checkbox"/>	Any Heart Condition	<input type="checkbox"/>
Gout	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Stomach/Duodenal Ulcer	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Glandular Fever	<input type="checkbox"/>	Liver or Kidney Condition	<input type="checkbox"/>	High Blood Pressure >140/90	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Cramps or Muscular Pain	<input type="checkbox"/>	Palpitations or Chest Pain	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Raised Cholesterol	<input type="checkbox"/>				

**Any pain or major injuries particularly in the following areas:**

Neck	<input type="checkbox"/>	Back	<input type="checkbox"/>	Knees	<input type="checkbox"/>	Ankles	<input type="checkbox"/>
------	--------------------------	------	--------------------------	-------	--------------------------	--------	--------------------------

**Please give details of any exercise you have been doing recently:**

.....

.....

**Statement:**

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

Signed : ..... Date : .....