Client Health Screen and Questionnaire

Private and Confidential

PERSONAL DETAILS

Name: _____ Sex: M F Date of Birth: ___ /____/ ___

Address: _____ Phone: _____

_____ Mobile: _____

Occupation: _____ Email: _____

MEDICAL HISTORY

KNOWN MEDICAL CONDITIONS

1. List any medications you take on a regular basis.

---

2. Do you have diabetes? **YES / NO**
If so, please indicate if it is insulin dependent diabetes mellitus (IDDM) or non insulin dependent diabetes mellitus (NIDDM). (Please circle) IDDM / NIDDM.

3. Have you had a stroke, heart attack or coronary revascularisation surgery?
YES / NO

4. Has your doctor ever told you that you have heart trouble, vascular disease, a heart murmur?
YES / NO

5. Do you have chronic obstructive pulmonary disease, interstitial lung disease or cystic fibrosis?
YES / NO

6. Do you take asthma medication? **YES / NO**

7. Are you, or do you have reason to believe, you may be pregnant?
YES / NO

8. Is there any other physical reason that prevents you from participating in an exercise program, (eg: osteoporosis, severe arthritis, mental illness, thyroid, kidney or liver disease?)
_____ **YES / NO**

jason@getfittas.com.au 0424 45 0424 www.getfittas.com.au

SIGNS AND SYMPTOMS

9. Do you suffer from pains in your chest, especially when you exercise?
YES / NO

10. Do you often feel faint or have severe dizziness during exercise?
YES / NO

11. Do you experience unusual fatigue or shortness of breath at rest or with mild exertion? **YES / NO**

12. Have you had an attack of shortness of breath that came on after you stopped exercising? **YES / NO**

13. Have you ever been woken by an attack of a shortness of breath during the night? **YES / NO**

14. Do you experience swelling or accumulation of fluid in or around your ankles? **YES / NO**

15. Do you get the feeling that your heart is suddenly beating faster, racing or skipping beats, either at rest or during exercise? **YES / NO**

16. Do you regularly get pains in your calves and lower legs during exercise which are not due to soreness or stiffness? **YES / NO**

17. Are there any other physical reasons or medical condition, or are you taking any medication(s) which could prevent you from undertaking an exercise program, or that you are concerned about?

_____ **YES / NO**

CARDIAC RISK FACTORS

18. Do you smoke cigarettes on a daily basis, or have you quit smoking in the past 2 years? **YES / NO**
If yes, how many cigarettes per day do you smoke? _____ Per day.

19. Has your doctor ever told you that you have high blood pressure?
YES / NO

20. Has your father, mother, brother or sister had a heart attack or suffered from cardiovascular disease before the age of 65?
YES / NO

21. What is your current blood pressure? _____/_____mmHg

jason@getfittas.com.au 0424 45 0424 www.getfittas.com.au

PERSONAL FITNESS GOALS

Please CIRCLE what you intend to achieve from your fitness programme or NUMBER in what order is your priority.

To loose weight

To tone up

To gain muscle definition

To improve aerobic capacity

To reduce stress

Other _____

_____

CURRENT PHYSICAL ACTIVITY

1. Does your occupation require you to sit a lot of the time? **YES / NO**

2. What are your current physical activity patterns?

   a. Frequency: _____ sessions per week

   b. Intensity: Sedentary Moderate Vigorous

   c. Duration: _____minuets per session

   d. How long have you been conducting this type of physical activity pattern?

   < 3 Months 3 – 12 months > 12 months

3. What type(s) of exercise do you currently do? (Eg; walking, jogging, yoga)

4. Do you have any prior or existing injuries that may prevent you from participating in an exercise program?

jason@getfittas.com.au 0424 45 0424 www.getfittas.com.au

NUTRITION

1. Is your cholesterol known to be high? ☐
2. Do you consider yourself overweight / obese? ☐
3. Are you fasting or dieting to reduce weight? ☐
4. Do you smoke? ☐
5. Are you pregnant or have you given birth in the last 6 weeks? ☐
6. Are you taking any prescribed medication that we need to be aware of? ☐

CLIENT DECLERATION

I have read and fully understood and completed this questionnaire. The answers I have given are accurate to the best of my knowledge.

I agree that I participate at my own risk any injury.

I understand and acknowledge the dangers associated with the consumption of alcohol or any mind altering drugs before and during my sessions and I take full responsibility for any injury, loss or damage associated with their consumption. I agree not to drink alcohol or take drugs prohibited by law before or during any sessions.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Signed Instructor: _____ Date: _____

jason@getfittas.com.au 0424 45 0424 www.getfittas.com.au

NOTES

jason@getfittas.com.au 0424 45 0424 www.getfittas.com.au