PRE-EXERCISE QUESTIONNAIRE

Name: Staff ☐ Student ☐ Community☐ (please tick)

Address: Suburb: Postcode:

Email: Phone No:

D.O.B: Referred by: Sign up Source:

Health Screening

Do you suffer from any of the following? (Please tick)

☐ Arthritis	☐ Back Problems	☐Muscle Tension	☐ Chest Pain
☐ Diabetes	☐ Heart Condition	☐Sports Injury	☐ Heart Trouble
☐ Epilepsy	☐ High/Low Blood Pressure	☐Asthma	☐Other:
☐ Bone/Joint Problems	☐ Liver/Kidney Condition	☐High Cholesterol	

Are you pregnant or attempting to fall pregnant? YES / NO Do you smoke? YES / NO

Are you currently on any medication? YES / NO

If yes, list details:

Emergency Contact Details

Name: Phone No:

Relationship to you:

I hereby warrant that all information on this form is correct. I acknowledge that I will not have any claim of any kind or nature for any illness or adverse change in medical condition or state of health arising directly or indirectly from any test or training programme I undertake. I acknowledge that I will not have any claim of any kind should any accident to my person or damage/loss of property occur. I furthermore declare myself familiar with all rules and regulations in force as laid down and agree to always adhere thereto.

Signed: Date:

Goal Setting (To be completed in your Kickstart initial assessment)

What do you wish to achieve? (Please tick)

☐ Reduce Body Fat	☐Stress Management	☐Sports Conditioning	☐ Weight Loss
☐ Improve Muscle Tone	☐Rehabilitation	☐Strength Training	☐Re-Shaping
☐ Increase Endurance	☐ Increase Muscle Mass	☐Body Building	☐Power/Speed

Why is it so important to achieve these goals?

When would you like to achieve these results by?

What will keep you motivated in achieving these goals?

What roadblocks do you foresee will limit you achieving these goals? How can you overcome them?

How long have you been thinking about this?

What stopped you starting sooner?

On a scale of 1 –10, how important is it to reach your goals?

How many times per week do you wish to train?