

Health Questionnaire

Name.....

Address.....

Telephone number: Mobile.....

e-mail Emergency contact.....

Please answer all the questions

Have you ever suffered from heart conditions? Y/N

Do you feel any pain during or after physical activity? Y/N

Do you ever feel faint or have spells of severe dizziness? Y/N

Do you have high or low blood pressure? Y/N Reading.....

Are you following any restrictive diets? Y/N

Please clarify.....

Do you smoke? Y/N

Do you suffer from asthma or any other breathing difficulties? Y/N do you take regular medication?.....

Are you epileptic? Y/N

Are you diabetic? Y/N If yes which type?.....

Do you have arthritis? Y/N If yes which type?

Do you have other conditions which may affect you during the session? Y/N

Details.....

Do you suffer with back pain? Y/N

Details.....

Have you undergone an operation in the last 6 months? Y/N

Details.....

Are you more than one stone overweight? Y/N

What exercise do you undertake regularly?.....

Are you taking any medication which may affect you during the session? Y/N

Details

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Has a health/medical practitioner e.g. Physiotherapist recommended exercise to you?

If yes please give details.....

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Please mention anything else which may be relevant (eg pregnancy, temporary conditions/short-term illnesses)

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Informed consent

I hereby state that I have read, understood and answered honestly the pre-exercise health screening questionnaire. Any questions I had were answered to my full satisfaction. Whilst every effort is made to keep the class safe and enjoyable, I am participating of my own free will and as with any exercise programme there is a risk of injury.

Name.....

Signature.....

Date.....

Data Protection

This information will only be kept whilst you are enrolled on a course. It will not be divulged to any third parties or used in any marketing activities.

