PRE-EXERCISE SCREENING QUESTIONNAIRE

In order for Australian Fitness Training to make a thorough assessment of your fitness requirements we ask that you complete the following information, this will also enable us to identify if medical attention should be sought prior to commencing a program.

Name:			
DOB:	Gender:	Height:	Weight:
Address:			
Phone:		Date:	
Email:			
Profession:		Emergency contact no:	
Emergency contact person:			

Stage 1 – Known Disease

1. List the medications you are taking:
   _____

2. Do you have Diabetes? No IDDM NIDDM
   If IDDM, for how many years have you had IDDM? _____Years

3. Have you had a stroke? No Yes

4. Has your doctor ever told you that you have heart trouble?
   No Yes

5. Would you say that your breathing is never quite right?
   No Yes

6. Do you have liver or kidney disease? No Yes

7. Are you, or do you have any reason to believe, that you are pregnant?
   No Yes

8. Is there any physical reason, which could prevent you from undertaking an exercise program, even if you wanted to e.g. cancer, osteoporosis, arthritis, mental illness, thyroid, kidney or liver disease? No Yes

Stage 2 – Signs and Symptoms

9. Do you often have pains in your heart and chest, especially with exercise?
   No Yes

10. Have you at any time in the last 12 months, had an attack of shortness of breath that came on during the day when you were not doing anything strenuous? No Yes

The information obtained will be treated as confidential and will not be released or revealed to any person without your written consent. The information obtained may be used for statistical or scientific purposes with your right of privacy retained.

11. Do you often feel faint or have spells of severe dizziness, particularly with exercise? No Yes

12. Have you had an attack of shortness of breath that came on after you stopped exercising, at any time in the last 12 months? No Yes

13. Have you at any time in the last 12 months been waken at night by an attack of shortness of breath? No Yes

14. Do you experience swelling or accumulation of fluid about the ankles? No Yes

15. Do you often get the feeling that your heart is beating faster, racing or skipping beats, either at rest or during exercise? No Yes

16. Do you regularly get pains in your calves and lower legs during exercise, which is not due to soreness or stiffness? No Yes

17. Has your doctor ever told you that you have a heart murmur? No Yes

18. Do you often experience fatigue when you are not doing anything strenuous, or when you are not doing anything at all? No Yes

Stage 3 – Cardiac Risk Factors

19. Do you smoke cigarettes daily? No Yes
If yes, how many cigarettes do you smoke each day on average? _____
If no, have you quit smoking in the last two years? No Yes

20. Do you have a close relative (i.e. father, mother, brother, sister) who has had a stroke, heart attack or cardiovascular disease? No Yes
If yes, what relation was this person? _____
At what age did he or she suffer a stroke/heart attack? _____
Did your relative die suddenly as a result of a stroke or heart attack? No Yes

21. Has your doctor ever told you that you have high blood pressure? No Yes

22. Do you know your systolic blood pressure? No Yes
If yes, what is it? _____

23. Do you know your diastolic blood pressure? No Yes
If yes, what is it? _____

24. Do you know your serum cholesterol level? No Yes
If yes, what is it? _____

25. Do you know your serum HDL level? No Yes

If yes, what is it? _____

Stage 4 – Exercise Intentions

26. Do you want to exercise vigorously (e.g. jogging) or only at a moderate intensity (e.g. brisk walking)? Moderate Vigorous

27. Does your occupation involve sitting for a large part of the day?
No Yes

28. Have you experienced menopause before the age of 45?
No Yes

29. Current activity patterns:

Intensity	**Frequency**	**Duration**
Nil	<2 times per week	<3 months
Walking	>3 times per week	3-12 months
Vigorous	>3 times per week	>12 months

30. What activities (if any) do you currently engage in?

Briefly describe these activities:

_____
_____
_____
_____

Circle one or a few

Walking Running
Cycling Swimming
Aerobics Weights
Circuit Boxing
Other

LIFESTYLE QUESTIONNAIRE

Listed below are several goals that can be achieved with regular exercise. Rank how important they are to you? (1=very important 10=least important)

Feel healthier (all round fitness)	1..2..3..4..5..6..7..8..9..10
Improve strength	1..2..3..4..5..6..7..8..9..10
Improve muscle size	1..2..3..4..5..6..7..8..9..10
Improve muscle tone	1..2..3..4..5..6..7..8..9..10
Improve aerobic capacity	1..2..3..4..5..6..7..8..9..10
Reduce body fat	1..2..3..4..5..6..7..8..9..10

Improve flexibility	1..2..3..4..5..6..7..8..9..10
Improve ability at sport	1..2..3..4..5..6..7..8..9..10
Improve to cope with stress	1..2..3..4..5..6..7..8..9..10
Improve social life	1..2..3..4..5..6..7..8..9..10

When do you prefer to exercise? Tick one or rank in order of priority

Before work Lunchtime Afternoon/Evening Other

If other, explain:

_____
_____
_____

What type of exercise interests you? Is there something you would like to try?

_____
_____
_____

Do you have any other comments / suggestions regarding the development of your exercise program?

_____
_____
_____

Is there any other reason you might have to prevent you participating in an exercise program?

_____
_____
_____

Thank you a member of the AFT Team will contact you soon.