

MORNING GLORY / VIGOUR IT OUT PRE EXERCISE QUESTIONNAIRE

Name: _____ Phone Number: _____
 Email: _____ Emergency Contact: _____ Number: _____

Please circle a 'YES' or 'NO' response to the following questions (circle):

- Are you male over 35 years or female over 45 years who has been inactive for a period of 6 months or more? YES NO
- Have you given birth within the last 6 weeks? YES NO
- Are you currently pregnant? YES NO
- Do you have any infections or infectious diseases? YES NO
- Are you on any prescribed medication? YES NO
- Are you receiving any treatment from a doctor, physiotherapist or any other health professional? YES NO
- Have you been hospitalised recently? YES NO

Do you have, or have you had?: (Please Tick ✓)

- | | | |
|--|---|--|
| <input type="checkbox"/> Palpitations/ Chest Pain | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness and Fainting |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver/ Kidney Conditions | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Low or High Blood Pressure | <input type="checkbox"/> Stomach/ Duodenal Ulcer | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Raised Cholesterol/ Triglycerides | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma/ Breathing Condition |
| <input type="checkbox"/> | | |

If 'YES' to any of the above, a **medical certificate** is required prior to commencing your exercise program in the interest of personal safety.

Do you have, or have you had?: (Please Tick ✓)

- | | |
|--|---|
| <input type="checkbox"/> Tendon/ Ligament Damage | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Surgery due to Injury | <input type="checkbox"/> Muscular pain |
| <input type="checkbox"/> Broken/ Fractured Bones | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Back/ Neck Pain | <input type="checkbox"/> Arthritic Pain |

If 'YES', give further information:

Please indicate what areas you would like help to achieve your health and exercise goals (Please Tick ✓)

- | | | |
|---|--|--|
| <input type="checkbox"/> Cardiovascular fitness | <input type="checkbox"/> Weight Control | <input type="checkbox"/> More Energy |
| <input type="checkbox"/> General health | <input type="checkbox"/> Sports Training | <input type="checkbox"/> Stress Relief |
| <input type="checkbox"/> Improved flexibility | <input type="checkbox"/> Strength Training | <input type="checkbox"/> Social/ Fun |
| <input type="checkbox"/> Increased Muscle Mass | <input type="checkbox"/> Rehabilitation | |

When do you wish to achieve these results by? _____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN THE STATEMENT BELOW.

- Work at a low level on your first visit and concentrate on learning to do the exercise with correct technique before increasing intensity.
- On each visit you will be able to work a little harder. Be sure to limit yourself to a pace where you can still talk comfortably.

STATEMENT

I recognise that Performants is not able to provide medical advice in regard to my fitness and that this information is used only as a guideline to determine the limitations of my ability to exercise. The information is used to assist in the exercise prescription process and to prescribe an appropriate exercise program suited to my specific needs. I hereby consent to voluntarily engage in a fitness appraisal to further determine my current state of fitness and ability to undertake a regular program of exercise. I have answered the questions to the best of my ability and understand the advice above.

Signature: _____

Date: _____