VCR Fitness

Personal Training & Pilates

Exercise Questionannire

Name_____

Date of birth_____

Address_____

Tel no_____

Email_____

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes / No

2. Do you feel pain in your chest when you do physical activity? Yes / No

3. In the past month, have you had chest pain when you were not doing physical activity? Yes / No

4. Do you lose balance because of dizziness or do you ever lose consciousness? Yes / No

5. Do you have a bone or joint problem (for example back, knee, hip) that could be made worse by a change in your physical activity? Yes / No

6. Is your doctor currently prescribing medication for your blood pressure or heart condition? Yes / No

7. Do you know of any other reason why you should not do physical activity? Yes / No

Are you currently exercising?_____

How often do you exercise?_____

What exercise do you currently do?_____

If not when did you last exercise regularly?_____

How many units of alcohol do you drink per week? _____

Do you smoke?_____

What are your reasons for exercising? _____

_____

_____

Have you had any of following?

Asthma	Yes / No
Epilepsy	Yes / No
Back pain	Yes / No
Joint problems	Yes / No
High blood pressure	Yes / No
Marked fatigue	Yes / No
Diabeties	Yes / No
Headaches	Yes / No

Other_____

Are you under the care of any consultant?_____

Do you take any medicines?_____

I understand that I am exercising at my own risk

Signed_____

Name_____

Date_____

NOTE: This physical activity clearance becomes invalid if your condition changes so that you would answer YES to any of the questions, having previously ticked NO. Please advise your trainer of any changes to your condition.