REYNARD STREET NEIGHBOURHOOD HOUSE
104a Reynard Street, Coburg 3058
039386 7128
www.rsnh.org.au

Exercise Pre-Screening Questionnaire

This is to be completed in preparation for physical activity. It is important that you disclose ALL of your existing medical conditions so that we/I may determine whether to seek further medical advice before commencing am exercise program. This questionnaire does not provide medical advice in any form and does not substitute advice from appropriately qualified professionals.

Title: ____ Name: _____ Surname: _____

Address: _____ Postcode: _____

Contact number: _____ DOB: _____ Age: _____

Email: _____

Emergency contact name: _____Number: _____

Have you been told you have a heart condition?	**YES**	**NO**
Have you ever had a stroke?	**YES**	**NO**
Do you have unexplained pains in your chest at rest or during physical exercise?	**YES**	**NO**
Do you consistently feel faint or suffer from spells of dizziness?	**YES**	**NO**
Do you suffer from asthma and require medication?	**YES**	**NO**
Do you suffer from type I or II diabetes?	**YES**	**NO**
Do you suffer from any major muscles or joint conditions that may limit or be aggravated by physical exercise?	**YES**	**NO**
Do you suffer from any medical conditions that may be made worse by participating in physical activity?	**YES**	**NO**
Do you suffer from high blood pressure over 140/90 or low blood pressure below 100/80?	**YES**	**NO**

DISCLAIMER:

If you have answered no to all the above questions and you are confident that you have no other concerns with your health, then you may proceed to participate in physical activity. If you have answered, yes to any of the questions above or are unsure, please seek a referral from your GP or allied health professional before commencing physical activity.

I believe to the best of my knowledge that all of the information I have provided on this form is accurate. In the case that my medical condition changes over the course of my training, I will inform my trainer and fill out a new exercise pre-screening questionnaire.

Client signature: _____ Trainer signature: _____

Date: _____ Date: _____

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Statement of Medical Clearance

Participant's Name: _____

Address: _____

Date of Birth: _____

Diagnosis: _____

Physician's Name: _____

Physician's Address: _____

Telephone Number: _____

○ YES. My patient _____ has no current unstable medical problems that are contraindication to participate in and group exercise program or resistance training program. I approve of and support his or her participation in this progressive strength, balance and flexibility training exercise program.

Comment:

○ NO. My patient _____ is not eligible to participate in the exercise due to his or her current medical status.

Comment:

Please indicate any special recommendations or specific comments:

_____

_____

Physician's Signature: _____ Date: _____