

# CLASSIC HEALTH PRE-EXERCISE QUESTIONNAIRE

Classic Health : Carlson St, - Old McRitchie Crescent Primary School

[www.classichealth.com.au](http://www.classichealth.com.au) ~ email: [admin@classichealth.com.au](mailto:admin@classichealth.com.au)

Phone: 86491000

Membership Number :	Expiry Date :
Member Name :	
Address :	Postcode
Phone Contact :	(H) (M) (W)

## Doctor's Contact Details

Name			
Address			
	Postcode		
Phone	(H)		(M)

## PERSONAL MEDICAL HISTORY

Are you currently taking any medication? Yes      No

If Yes, please give details : .....

.....

Are you taking any medication which could cause a reaction while exercising? Yes      No

If Yes, please give details : .....

.....

Are you currently under the care of the physician for any reason at all? Yes      No

If Yes, please give details : .....

.....

.....

Do you currently smoke or have you smoked in the last 6 months? Yes      No

If Yes, please give details of how much : .....

.....

Do you have or have you had any of the following?

Condition	Yes/No	Details	Do you have your doctors clearance?
Heart Attack or Disease			
Stroke			
Chest Pain			
High or Raised Cholesterol			
Diabetes			
Cancer			
Hernia			
Arthritis			
Thyroid			
Anemia			
Migrane or Chronic Headaches			
Joint Problems			
Asthma			
Epilepsy			
Pneumonia			
Menstrual Disorders			
Any other condition			

Have you ever been injured in any of the following areas?

Body Part	Yes/No	Description & when	Do you have doctors clearance?
Neck			
Shoulders			
Arms			
Abdomen			
Back			
Legs			

Does your doctor know you are beginning a new program or activity? Yes No

If Yes, does he/she have any objections or have they given any modifications/restrictions?

Yes No

If Yes, please give details : .....

Are you pregnant or have you had a baby in the last 6 weeks? Yes No

If Yes, do you have your doctors clearance in order to exercise? Yes No

What things in your life are causing you stress on a daily/weekly basis? .....

**Exercise**

Are you currently exercising? Yes No

If Yes,

Type of Exercise	Frequency	Duration	Exertion Level	How long have you been exercising for?

How many hours of sleep do you normally get each night? 4 5 6 7 8 9 10 11 12

What would you like to achieve from exercising? .....

What type of exercise do you prefer? .....

**RELEASE**

I know of no physical or medical condition which I, or my Doctor, feel could be aggravated by my using the Equipment and facilities or, participating in activities sponsored by this organisation. I agree to advise management in writing if any of the above information changes or if my Doctor advises me to stop, reduce or otherwise adjust my exercise regimen. I will advise management immediately if I injure myself in anyway while on organisation property. The above information I have given on this form is, to the best of my knowledge, complete and accurate.

I understand that the information supplied will be treated with the utmost confidence.

Participation in activities at Classic Health will be undertaken at my own risk.

SIGNED :

DATED : / /