

PRE EXERCISE FORM

Train Hard, Eat Well and Expect Results!

Name: _____ Date of birth: _____

Address: _____

Ph (H): _____ (W): _____

In an Emergency whom can I contact?

Name: _____ Relationship: _____

Ph (H): _____ (W): _____

Personal physician

Name: _____ Ph: _____

This information will be kept confidential. (please circle where appropriate)

1. Have you ever had a heart attack, coronary revascularization surgery or a stroke? (Yes / No)
2. Has your doctor ever said you have a heart condition, vascular disease a heart murmur or indicated you should restrict your physical activity? (Yes / No)
3. Do you ever feel pain in your chest, especially when you do physical activity? (Yes / No)
4. Do you ever get pain in your calves, buttocks or at the back of your legs during exercise that is not due to soreness or stiffness? (Yes / No)
5. Do you ever feel faint or get dizzy and loose you balance, particularly with exercise? (Yes / No)
6. Do you ever get the feeling that your heart is suddenly beating faster, racing or skipping beats, either at rest or during exercise? (Yes / No)
7. Do you have chronic obstructive pulmonary disease, interstitial lung disease, or cystic fibrosis? (Yes / No)
8. Have you ever had an attack of shortness of breath that developed when you were not doing anything, or developed after you stopped exercise at any time in the last 12 months? (Yes / No)
9. Do you have diabetes, what type and if so do you have trouble controlling your diabetes? (Yes / No)
10. Do you have any ulcerated wounds or cuts on your feet that do not seem to heal? (Yes / No)
11. Do you have any liver, kidney or thyroid disorders? (Yes / No)
12. Do you experience unusual fatigue or shortness of breath with usual activities? (Yes / No)
13. Do you have high blood pressure (Above 140/90)? (Yes / No)
14. Do you know of any physical or medical reason why you should not participate in physical activity, or are you currently on any prescribed medication that could prevent you for taking part in physical activity? (Yes / No)

If you answered 'yes' to **one or more** of the above **questions** you are a **considered a high risk** client. You will need to talk with your doctor before you become physically active, discuss which questions you answered yes to and talk to your doctor about the kind of activity you wish to participate in and follow his/her advice. We **will need** a **medical clearance** from the doctor **before training** can commence. I have a medical clearance form that I would like you to have signed by your doctor.

If your health changes so you then answer 'yes' to any of the above questions, please inform me and seek guidance from a doctor before continuing with any more exercise.

Signature: _____ Date: _____

PRE EXERCISE FORM 2

1. Male, are you over the age of 45? Female, are you over the age of 55? (Yes / No)
2. Are you a smoker or have you quit within the last 6 months? (Yes / No)
3. Do you have a sedentary occupation and do no regular exercise? (at least 150 min of moderate exercise every week) (Yes / No)
4. Do you have a BMI over 30, waist girth over 100cm? (Yes / No)
5. Do you have Hypertension? High blood pressure confirmed by measurement on at least two separate occasions.
Systolic blood pressure 140 mmHg or greater
Diastolic blood pressure 90 mmHg or greater
Or are you using anti hypertensive medication? (Yes / No)
6. Do you have a family history of cardiovascular disease or sudden death? (Yes / No)
Before 55 years of age in father or other first degree male relative,
Before 65 years of age in mother or other first-degree female relative.
7. Do you have impaired fasting glucose? (Yes / No)
Fasting glucose ≥ 6.1 mmol.L⁻¹ on two separate occasions.
8. Do you have a total serum cholesterol concentration of >5.2 mmol.L⁻¹, have high density lipoprotein cholesterol ≤ 9 mmol.L⁻¹. Or are you using lipid-lowering medication? (Yes / No)
9. Are you pregnant or have you had a baby in the last six months? (Yes / No)
10. Do you have a joint problem that could be made worse by exercise? (Yes / No)

If you answered **yes to question 1 only** you are considered a **moderate risk**. We **can begin** the aerobic testing phase and begin training **at a low to moderate level**.

To begin a vigorous program you we will need a medical clearance.

If you answered **yes to two or more** of the above **questions** you are considered a **moderate risk**. We **can begin** the aerobic testing phase and train **at a low to moderate level**.

To begin a vigorous program you we will need a medical clearance.

If you honestly answered **'no' to all or 'yes' to only one** of the above **questions excluding question 1** you are considered a **low risk**, we can start the aerobic testing phase and be reasonably certain you can safely increase your level of physical activity gradually.

If at a later stage you would your health changes so you then answer 'yes' to any of the above questions, you should inform me before continuing with any more exercise so we assess if it is safe to continue training.

Name (printed):

Signature:

High-risk categories:

1. If client has any known cardiovascular, cerebrovascular, respiratory or metabolic disease.
2. If the client shows one or more signs/symptoms of major cardiovascular, respiratory or metabolic disease.
3. If client shows conditions that require a medical opinion.

A client who is determined to be at moderate risk must obtain a medical clearance before commencing a high intensity exercise program (you can begin training at low intensity until they are medically cleared).

A client who is determined to be at high risk must obtain a medical clearance prior to starting any exercise routine.