Courtenay Recreation

Health & Fitness Screening

Courtenay Recreation

Name:_____Cell #:_____Age:_____

How do you best wish to communicate? (circle one): email text phone

Phone #:_____ Email:_____

Regular exercise is associated with many health benefits, yet any change of activity may increase the risk of injury. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly.

This form MUST be returned BEFORE you participate in any Personal Training Program. Details on this form are strictly confidential and used by the personal trainer solely for the purpose of health screening & program prescription.

Please be assured that these steps are necessary in order to serve you best

Category 1

Yes	No	
☐	☐	1. Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity?
☐	☐	2. When you do physical activity, do you feel pain in your chest?
☐	☐	3. When you were not doing physical activity, have you had chest pain in the past month?
☐	☐	4. Do you ever lose consciousness or do you lose your balance because of dizziness?
☐	☐	5. Do you have a joint or bone problem that may be made worse by a change in your physical activity?
☐	☐	6. Is a physician currently prescribing medications for your blood pressure or heart condition?
☐	☐	7. Are you pregnant?
☐	☐	8. Do you have insulin dependent diabetes?
☐	☐	9. Are you MORE than 35 lbs. overweight?
☐	☐	10. Do you know of any other reason you should not exercise or increase your physical activity?
☐	☐	11. Have you recently sustained any type of muscle or bone injury? If yes, what was the injury? _____
☐	☐	12. Are you currently seeing a Physiotherapist or Chiropractor? If yes, for what? _____
☐	☐	13. Are you aware of any other conditions not mentioned that may affect your training? If yes, please provide details_____

Have you ever been, or are you currently affected by any of the following conditions?

Category 2			Category 3 (within last 12 months)			Category 4 (within last 12 months)		
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Hypertension	Y	N	Pregnancy	Y	N	Neck or back pain	Y	N
Respiratory Disorders	Y	N	Prescription Medications	Y	N			
Heart Trouble	Y	N	Migraines	Y	N	Joint injury	Y	N
Stroke	Y	N	High Cholesterol	Y	N			
Blood Disorders	Y	N	Surgery	Y	N	Musculoskeletal injury	Y	N
Epilepsy or Seizures	Y	N	Asthma	Y	N			
Diabetes	Y	N	Hernia	Y	N			

What kind of exercise program are you currently involved in?_____

How often_____ On a regular basis? ☐ Yes ☐ No

Rank your exercise goals in order of importance from 1st to 3rd

Balance	_____		
Muscle Building	_____	Fat Loss	_____
Muscle Toning	_____	Injury Rehabilitation	_____
Strength Development	_____	Stress Relief	_____
Sports Specific Training	_____	Flexibility	_____
Cardiovascular Fitness	_____	Power Training	_____

Other – please specify _____

What types of activities are you currently participating in (**P**=participating)?
What activities are you interested in (**I**=interested)?

Biking	_____	Suspension Trainers	_____	Pilates	_____
Weights	_____	Running / Jogging	_____	Swimming	_____
Yoga	_____	Aerobics/Fitness Classes	_____	Circuit Training	_____
Walking	_____	Swiss/Bosu Ball	_____		

Other, please specify_____

Is your Doctor aware that you are participating or begining an exercise program?
(circle which applies)

1. Yes, my doctor is aware of my exercise program.
2. No, my doctor is not aware and I will consult with him/her prior to starting an exercise program.
3. No, I am aware that I should consult my doctor before beginning any exercise program, but have chosen not to do so.