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Pre-Exercise Screening Questionnaire

This screening tool does not provide advice on a particular matter, nor does it substitute for advice from an appropriately qualified medical professional. No warranty of safety should result from its use. The screening system in no way guarantees against injury or death. No responsibility or liability whatsoever can be accepted by Personal Best for any loss, damage or injury that may arise from any person acting on any statement or information contained in this tool.

Privacy Policy

The attached questionnaire asks personal information about your health, fitness and lifestyle to ensure that both a safe and effective service can be provided. Personal Best has a comprehensive privacy policy governing how any personal information collected will be used. For further information, go to www.personalbestfitnessstudios.com.au

Name		Phone		Date	
Emergency Contact		Emergency Contact Phone			

PART 1

AIM: To identify those individuals with a known disease, or signs or symptoms of disease, who may be at a higher risk of an adverse event during physical activity or exercise. This stage is self-administered and self-evaluated

		Please circle	
1.	Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke?	Yes	No
2.	Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?	Yes	No
3.	Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	Yes	No
4.	Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months?	Yes	No
5.	If you have diabetes (Type I or Type II) have you had trouble controlling your blood glucose in the last 3 months?	Yes	No
6.	Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?	Yes	No
7.	Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise?	Yes	No

IF YOU ANSWERED 'YES' to any of the 7 questions, please seek guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise

IF YOU ANSWERED 'NO' to all of the 7 questions, and you have no other concerns about your health, you may proceed to undertake light-moderate intensity physical activity/exercise

I believe that to the best of my knowledge, all of the information I have supplied within this tool is correct.

Signature **Date**

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PART 2

AIM: To identify those individuals with risk factors or other conditions to assist with appropriate exercise prescription. This stage is to be administered by a qualified exercise professional.

		RISK FACTORS
1. Age: Gender:	≥ 45yrs Males or ≥ 55yrs Females = +1 risk factor	
2. Family history of heart disease (e.g. stroke, heart attack) *Relative* / *Age* / *Relative* / *Age* Father / Mother Brother / Sister Son / Daughter	If male < 55yrs = +1 risk factor If female < 65yrs = +1 risk factor Maximum of 1 risk factor for this question	
3. Do you smoke cigarettes on a daily or weekly basis or have you quit smoking in the last 6 months? Yes No	If yes, = +1 risk factor	
4. Describe your current physical activity/exercise levels: Sedentary / Light / Moderate / Vigorous Frequency (sessions per week) Duration (minutes per week)	If physical activity level < 150 min/ week = +1 risk factor If physical activity level ≥ 150 min/ week = -1 risk factor (vigorous physical activity/ exercise weighted x 2)	
5. Have you been told that you have high cholesterol? Yes No	If yes, = +1 risk factor	
6. Have you been told that you have high blood sugar? Yes No	If yes, = +1 risk factor	
7. Resting Blood Pressure (mmHg): /	SBP ≥140 mmHg or DBP ≥90 mmHg If yes, = +1 risk factor	
8. Body Mass Index (BMI) Weight (kg): Height (m): BMI (kg/m2) =	BMI ≥ 30 = +1 risk factor	
9. Waist to Hip Ratio (WHR) Waist (cm): Hips (cm): WHR (waist/hips) =	A WHR > 0.9 for men and > 0.8 for women = +1 risk factor	
	Part 2 Total Risk Factors	

Risk Stratification

RISK FACTOR ≥ 2 – MODERATE RISK CLIENTS
Individuals at moderate risk may participate in aerobic physical activity/exercise at a light or moderate intensity

RISK FACTOR < 2 – LOW RISK CLIENTS
Individuals at low risk may participate in aerobic physical activity/exercise up to a vigorous or high intensity

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PART 3

AIM: To identify those individuals with risk factors or other conditions to assist with appropriate exercise prescription. This stage is self-administered and self-evaluated

Respiratory System

1. Do you have any lung problems or breathing difficulties? Yes No	If yes, provide details
2. Have you ever been diagnosed as having emphysema? Yes No	If yes, provide details
3. Have you ever been diagnosed as having bronchitis? Yes No	If yes, provide details
4. Have you ever been diagnosed as having asthma? Yes No If yes, is your asthma exercise-induced? Yes No	If YES, what level of asthma: ☐ mild ☐ moderate ☐ severe What medication and dosage are you taking?
5. Do you experience shortness of breath? Yes No	If YES, under what conditions:

Musculo-Skeletal System

1. Have you ever been diagnosed as having osteoporosis? Yes No	If YES, in which bones/areas:
2. Have you ever experienced any back/ neck problems and/or pain? Yes No Yes, but not now	If YES, in which areas: ☐ Neck ☐ Upper back ☐ Mid-back ☐ Lower Back ☐ Pelvis ☐ Coccyx
3. Do you experience any other bone or joint pain (e.g. arthritis, aches and pains)? Yes No	If YES, please specify the joint or bones affected:
4. Do you have any muscle, bone or joint pain or soreness that is made worse by particular types of activity? Yes No	If YES, provide details
5. Have you ever suffered any major soft tissue injury (e.g. torn muscle, ligaments, cartilage)? Yes No	If YES, provide details and treatment received

General Conditions

Do you or have you ever suffered from any of the following:

1. Psychological disorders Yes No	☐ past - but not now ☐ at present
2. Infectious diseases or viruses, e.g. HIV, Hepatitis Yes No	☐ past - but not now ☐ at present
3. Are there any other health or medical concerns that we should be aware of? Yes No	If YES, please specify
4. Have you spent time in hospital (including day admission) for any medical condition/illness/injury during the last 12 months? Yes No	If yes, provide details
5. Are you currently taking a prescribed medication(s) for any medical conditions(s)? Yes No	If yes, what medical conditions?
6. Are you pregnant or have you given birth within the last 12 months? Yes No	If yes, provide details. I am _____ months pregnant I am _____ months post-natal