



CITY OF  
**COURTENAY**  
Recreation

# Courtenay Recreation

## Health & Fitness Screening

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Name: \_\_\_\_\_ Text #: \_\_\_\_\_ Age: \_\_\_\_\_

How do you best wish to communicate?: \_\_\_\_\_

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 this centre solely for the purpose of health screening & program prescription and will be returned to you or destroyed after your sessions are completed.

Please Be Assured That These Steps Are Necessary In Order To Serve You Best

### Category 1

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity?           |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. When you do physical activity, do you feel pain in your chest?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. When you were not doing physical activity, have you had chest pain in the past month?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you ever lose consciousness or do you lose your balance because of dizziness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a joint or bone problem that may be made worse by a change in your physical activity?                        |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is a physician currently prescribing medications for your blood pressure or heart condition?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you pregnant?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have insulin dependent diabetes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you MORE than 35 lbs. overweight?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you know of any other reason you should not exercise or increase your physical activity?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you recently sustained any type of muscle or bone injury? If yes, what was the injury? _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Are you currently seeing a Physiotherapist or Chiropractor? If yes, for what? _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 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		Category 4			
			(within last 12 months)		(within last 12 months)			
	<b>Yes</b>	<b>No</b>		<b>Yes</b> <b>No</b>		<b>Yes</b>	<b>No</b>	
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 _____	Fat Loss _____
Muscle Building _____	Injury Rehabilitation _____
Muscle Toning _____	Stress Relief _____
Strength Development _____	Flexibility _____
Sports Specific Training _____	Power Training _____
Cardiovascular Fitness _____	
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 _____		