Courtenay Recreation

Adult Health & Fitness Screening

Name:_____Phone:_____Age:_____

Address:_____

CHECK off the program you are registering for:

☐ Private Personal Training ☐ Semi Private Personal Training

☐ Personal Training _____ Sessions ☐ Other _____

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.

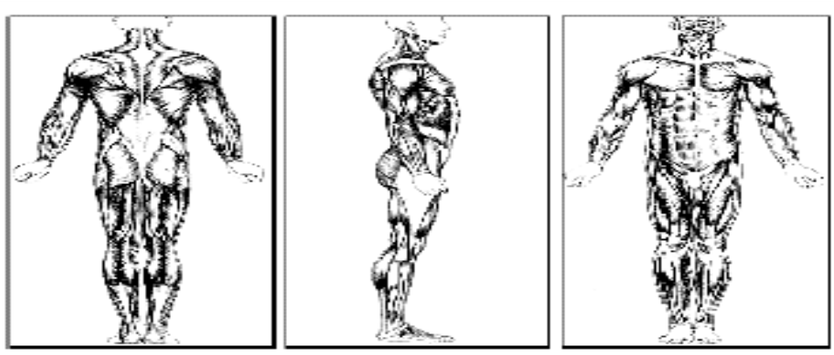
This form ***MUST*** be returned ***BEFORE*** you participate in any Personal Training Program. PLEASE NOTE: If you answered yes to 2 or more of the below questions, we will require that you take the Par MedX form to your doctor for approval. If you honestly answered no to all questions, you can be reasonably sure that you can safely participate in an appropriate exercise / wellness 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 appointment date.***

♦ 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. Have you been seeing a Physiotherapist or Chiropractor in the last 12 months? If yes, for what? _____
❑	❑	13. Are you aware of any other conditions not mentioned that may affect your training? If yes, please provide details_____

Please circle any parts of your body that are injured, sore or might cause you concern during physical activity. (Please turn form over for more required information.)



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

How often_ _____ On a regular basis? ❑ Yes ❑ No

Does your physician know you are participating in this exercise program? ❑ Yes ❑ No

Has your physician ever advised you not to exercise? ❑ Yes ❑ No

Special physical considerations: _____

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

Category 2			Category 3			Category 4		
	Yes	**No**	*(within last 12 months)*			*(within last 12 months)*		
				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			

Date of most recent medical checkup:_____ Condition:_____

Family Doctor:_____Phone:_____

Physiotherapist or Chiropractor:_____Phone:_____

In case of Emergency, please contact: _____

I have completed the Health & Fitness Screening Form and I have truthfully answered all questions to the best of my ability. I have been informed and fully understand that participation in the program may involve certain risks to me and I agree to accept those risks. I hereby release my instructor and all sponsoring agencies from responsibility for any injuries I may receive as a result of participation in this program. I certify that my level of physical condition determined by my physician or myself will allow me to safely participate in this program. I further state that I have read and understand this release and that I am legally competent to sign this.

_____ _____

Participants Signature ***Date***

Thank you,
Courtenay Recreation

Please check any appointment availability times if registering for Personal Training or consultations

❑ Monday ❑ Tuesday ❑ Wednesday
❑ Thursday ❑ Friday ❑ Saturday
❑ Sunday
❑ Mornings ❑ Afternoons ❑ Evenings

We will contact you to set up an appointment

FITNESS SCREENING KEY

Client has not identified any risk factors	→	Clear for testing & /or class participation
Client indicated YES to 2 or more category 1 conditions	→	Medical Clearance required from physician
Client indicated YES to 2 or more in category 2	→	Medical Clearance required from physician
Client indicated YES to 2 or more in category 3	→	Medical Clearance required from physician
Client indicated YES to 2 or more in category 4	→	Medical Clearance required from relevant health professional

last updated December 2013

The following information is required for anyone requesting a Fitness Testing Evaluation, Basic Consultation or Personal Training Package and should be included with the Health & Fitness Screening form

	Yes	**No**
Do you engage in any **regular** physical activity?	y	n
Would you describe your job as physical?	y	n

If you have answered yes to any of the above, then please detail below:

_____

Sessions / Week 1 2 3 4 5 6 7 +

Session Duration □ Under 1 hour □ 1.5 hours □ Over 2 hours

Please circle preferred workout days Mon Tues Wed Thurs Fri Sat Sun All

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

Muscle Building _____
Muscle Toning _____
Strength Development _____
Sports Specific Training _____
Cardiovascular Fitness _____
Fat Loss _____
Injury Rehabilitation _____
Stress Relief _____
Flexibility _____
Power Training _____
Other – please specify _____

Tick which types of activities you would like to include in your program to achieve the above goals

Running / Jogging _____ Weights _____ Swimming _____
Circuit Training _____ Aerobics _____ Pilates _____
Walking _____ Yoga _____ Swiss Ball _____
Other, please specify _____

Do you eat the following meals regularly? What size meal would you usually have?

Breakfast	Y	N	or Occasionally	Small	_____
Lunch	Y	N	or Occasionally	Moderate	_____
Dinner	Y	N	or Occasionally	Large	_____
Morning Snack	Y	N	or Occasionally	Very Large	_____
Afternoon Snack	Y	N	or Occasionally	Uncertain	_____
				Meals per day?	_____

Do you drink alcohol? Y N If so, estimate how many per week? _____
Do you smoke? Y N If so, how many per day? _____

How often do you eat or drink the following?
(Please highlight the relevant unit of time)

Fruits / Vegetables _____ serves / day / wk
Fried / Fatty Foods _____ serves / day / wk
Meat / Poultry _____ serves / day / wk
Soft Drinks (cola, etc) _____ cans / day / wk
Water _____ glasses / day
Mild & Dairy Produce _____ serves / day/ wk
Breads & Cereals _____ serves / day / wk

In order to best serve you, we rely on the accuracy of the information supplied to us on this form. If you believe this information to be accurate and agree to notify a staff member should any of this information change, please sign below.
Client:_____ Date:_____

Evaluator:_____ Date: _____