

# ADULT PRE-EXERCISE SCREENING TOOL

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 Exercise and Sports Science Australia, Fitness Australia or Sports Medicine Australia for any loss, damage or injury that may arise from any person acting on any statement or information contained in this tool.

Name:  Date of Birth:

Gender:  MALE  FEMALE Membership Number

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/exercise. This stage is self administered and self evaluated.

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: \_\_\_\_\_

8	Have you spent time in hospital (including day admission) for any medical condition/illness/injury during the last 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide details
9	Are you currently taking a prescribed medication(s) for any medical conditions(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide details
10	Are you pregnant or have you given birth within the last 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide details. I am _____ months pregnant or postnatal (circle).
11	Do you have any muscle, bone or joint pain or soreness that is made worse by particular types of activity? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide details

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### PERSONAL MOTIVATION FOR MEMBERSHIP

- |                     |                          |                            |                          |
|---------------------|--------------------------|----------------------------|--------------------------|
| Improve Health      | <input type="checkbox"/> | Weight Loss                | <input type="checkbox"/> |
| Improve Fitness     | <input type="checkbox"/> | Stress Relief              | <input type="checkbox"/> |
| Improve Strength    | <input type="checkbox"/> | Improve Sports Performance | <input type="checkbox"/> |
| Improve Muscle Tone | <input type="checkbox"/> | Injury Recovery            | <input type="checkbox"/> |
| Improve Flexibility | <input type="checkbox"/> |                            | <input type="checkbox"/> |

#### PERSONAL PREFERENCES FOR FITNESS

- |                                |                          |                              |                          |
|--------------------------------|--------------------------|------------------------------|--------------------------|
| Group Fitness Classes          | <input type="checkbox"/> | Functional Strength Training | <input type="checkbox"/> |
| Spin Classes                   | <input type="checkbox"/> | Body Weight Training         | <input type="checkbox"/> |
| Electronic Cardio Equipment    | <input type="checkbox"/> | Personal Training            | <input type="checkbox"/> |
| Free Weights                   | <input type="checkbox"/> | Small Group Training         | <input type="checkbox"/> |
| Cable Weights                  | <input type="checkbox"/> | Stretching                   | <input type="checkbox"/> |
| High Intensity Training (HITs) | <input type="checkbox"/> | Pilates/Yoga                 | <input type="checkbox"/> |
| Boxing                         | <input type="checkbox"/> | Running                      | <input type="checkbox"/> |
| Staying Active (over 55s)      | <input type="checkbox"/> | Cycling                      | <input type="checkbox"/> |

#### Office Use Only

<b>Medical Certificate Required</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Date</b>	<input type="text"/>
<b>Referral Letter Provided</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Staff Member</b>	<input type="text"/>