

- 🕒 Aqua Therapy 🕒 Aqua Exercise 🕒 Massage 🕒 Sports Rehabilitation Therapy 🕒 Swimming Lessons
- 🕒 Pilates 🕒 Manual Lymphatic Drainage (MLD) 🕒 Corrective Exercise 🕒 Seated Exercise 🕒

Health Questionnaire

So that we may provide you with the best possible service, please complete all information as accurately as possible. A doctor's clearance may be required prior to exercising.

Personal Details:

Name:		Address:		Date:	
				Gender:	
Tel (H):				Age:	
Tel (W):				D O B:	
Tel (M):		Email:			

Emergency Contact/Next of Kin:

Name:		Tel: (W/H/M)	
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GP Details:

Name:		Address:	
Tel (W):			
Email:			

Please tick where applicable:

Staff:		Student:		Public:	
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Please read this carefully. If you are unsure about any aspect of this questionnaire, please ask us for assistance. It is very important that you answer all the questions honestly and accurately and where necessary consulting with your Doctor.

Your current fitness level:

Do you currently take part in any form of physical activity? If Yes, please specify

How physically fit do you feel you are?

Very Fit:		Above Average:		Average:		Below Average:		Unfit:	
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Personal Health Details:

Weight		Fat Free Mass	
Height		Blood Pressure	
BMI		Resting Heart Rate	
Body Fat		Lung Capacity	
Fat Mass			

Please answer the following questions by crossing out YES or NO where applicable:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? YES/NO

Do you feel a pain in your chest when you do any physical activity? YES/NO

Do you have any problems with your blood pressure? High/Low

Is your doctor currently prescribing any medication for your blood pressure or a heart condition? YES/NO

In the past month have you had chest pain when you were not doing physical activity? YES/NO

Do you lose your balance because of dizziness or do you ever lose consciousness? YES/NO

If yes, please specify:

Do you have a bone or joint problem that could be made worse by a change in your physical activity? YES/NO

Do you have any breathing problems which may affect your ability to exercise? YES/NO

Are you or is there any chance you could be pregnant? YES/NO

Are you Pre-operative or post operative? YES/NO

If YES, what is/was your operation for, and do you have any resulting complications?

Do you know of any other reason why you should not do physical activity? YES/NO

If you answered YES to one or more questions

Talk to your doctor by phone or in person BEFORE you start becoming much more physically active or before you attend any classes or treatments. Tell your Doctor about the PARQ and which questions you answered YES to, preferably take it with you when you see your Doctor.

If you honestly answered NO to all the questions

You can be reasonably sure that you can start to become more physically active.

Delay becoming more active

If you are not feeling well because of a temporary illness such as a cold or fever, please inform the Rehab therapist

Important

If your health changes in anyway, so that you answer YES to any of the above questions you must advise your Rehab therapist immediately and ask whether you should change your physical activity plan

Personal History

Do you have or have you had any of the following (or similar) conditions:

Lower Back Pain		Arm/Elbow	
Upper Back Injury		Nerve Damage	
Hip/Pelvis Injury		Bone Fracture	
Head/Neck Injury		Shoulder/Clavicle Injury	
Foot/Ankle Injury		Wrist/Hand Injury	
Muscular Injury		Knee Injury	

If YES to any of the above, please answer the following:

What caused the pain?

How long ago did the injury occur?

When do you feel pain most?

Did you have treatment for the injury?

Any specific restrictions / recommendations from primary / previous care attendant? (Physician, physiotherapist etc)

Do you consider yourself to have any of the following disabilities:

Visual Impairment		Hearing Impairment	
Physical Impairment		Learning Disability	
Multiple Impairment		Other	

If YES to any of the above, please give details:

Personal/Family History:

Please tick the appropriate box if either you or an immediate family member has ever been diagnosed with any of the following conditions:

Condition	Self	Sibling	Parent
Allergies			
Anaemia			
Angina or chest pain			
Anxiety / panic disorder			
Arthritis / gout			
Asthma / hay fever			
Cancer			
Cardiac disease			
Chemical dependency (alcohol, drugs)			
Chronic bronchitis			
Depression			
Diabetes			
Emphysema			
Epilepsy			
Haemophilia / slow healing			
Hepatitis / jaundice			
High cholesterol			
Hypertension (high blood pressure)			
Hypoglycaemia (low blood sugar)			
Hypotension (low blood pressure)			
Kidney disease / stones			
Liver disease / cirrhosis			
Lupus			
Migraine / headaches			
Multiple sclerosis			
Osteoporosis /osteopenia			
Pneumonia			
Polio			
Rheumatic / scarlet fever			
Rheumatoid arthritis			
Shortness of breath			
Stroke			
Thyroid problems			
Tuberculosis			
Ulcers / stomach problems			
Urinary tract infection			
Other			
Other			

Please indicate any medications which you are taking (name & reason):

Smoking

Do you currently smoke? YES/NO

If YES how many per day?

If you have quit smoking, when was this?

Exercise, Sport & Work History

Do you regularly participate in physical activity, exercise or sport? YES/NO

How many months/years have you been exercising regularly?

Activity (sport related, recreational)	Duration (length of time you exercise for each episode)	Frequency (how often do you perform this type of activity?)	Intensity (how hard are you working at this activity: high/moderate/low)

How many hours per week do you work?

What is your occupation?

How many hours per week do you study?

How many hours per week are you sitting at a desk or using a laptop?

Where did you hear about BODYACTIF?

Cancellation Policy:

Please note that a discretionary 100% cancellation charge will apply if you fail to give 24 hours notice of cancellation or if you fail to attend an appointment.

Declaration

I confirm that all the information given is, to the best of my knowledge true and accurate and that I take full responsibility for my actions during all exercise or treatment sessions and that trainers will not be held responsible for any injuries incurred due to withholding any information regarding and predisposing conditions or injuries. Also that if my condition changes I will complete a new PARQ questionnaire.

Signature:	Date:
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Disclaimer

It is advised that you discuss this questionnaire with your Doctor. If however you do not wish to advise your doctor of your intent to exercise you do so entirely at your own risk..

Signature:	Date:
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