FUTURE FITNESS GROUP – HEALTH QUESTIONNAIRE

PERSONAL DETAILS

CLIENT NAME: _____

DATE OF BIRTH: _____/_____/_____

AGE: _____

ADDRESS: _____

POSTCODE: _____

CLIENT EMAIL: _____

CLIENT CONTACT NUMBER:

Home: _____

Mobile: _____

EMERGENCY CONTACT NAME: _____

E.C NUMBER: _____

GP NAME: _____

GP CONTACT NUMBER: _____

GP ADDRESS: _____

MEDICAL HISTORY

Please Tick either YES/NO to the following	YES	NO
1. Has a doctor ever advised you not to participate in exercise *If YES, please state reason:* ..... 2. Are you currently injured or recovering from an injury? *If YES, please state what kind and the severity of injury and if applicable how long you have been recovering:* ..... 3. Have you had any operations within the last 2 years? *If YES, please state what the operation(s) were for and the date of the operation(s):* ..... 4. Have you ever had any Heart conditions? *If YES, please state which condition:* ..... 5. Have you ever had a stroke? *If YES, please state how long ago* ..... 6. Have you ever experienced chest pain of any kind? *If YES, please state when you have had it and how often it occurs:* ..... 7. Have you ever had any respiratory problems E.g. Asthma? *If YES, please state which condition and when you have had it:* ..... 8. Have you ever experienced dizziness, loss of balance or do you ever lose consciousness? If YES, please state when and how often it occurs: ..... 9. Have you had any bone, joint or muscular problems? *If YES, please state which condition or problem:* ..... 10. Do you have Diabetes? *If YES, please state which Type and if you are on any medication for it:*	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

11. Have you ever had low or high blood pressure? ☐ ☐
If YES, please state Low or High and medications if you are taking any:

.....

12. Do you suffer from epilepsy? ☐ ☐
If YES, please state what triggers it and what medication you are taking:

.....

13. Are you taking any medication that may affect exercise? ☐ ☐
E.g. Painkillers,
If YES, please state which medication you are taking:

.....

14. Are you taking any drugs Prescribed or Non-Prescribed ☐ ☐
If YES, please state what drug(s) it is and dosage:

.....

15. Do you have any Allergies? ☐ ☐
If YES, please state which allergy and severity of it:

.....

16. Are you Pregnant or have recently given birth? ☐ ☐
If YES, please state how late into your pregnancy you are or how long since you have given birth.

.....

17. Is there anything else that could affect your ability to exercise? ☐ ☐
If YES, please state what that reason is:

.....

18. Do you or have you had any symptoms of Covid-19 recently? ☐ ☐
If YES, please state what that reason is:

.....

If you answered YES in any of the previous questions it is recommended that you seek doctors' advice prior to exercise.

GP Referral needed?

Yes ☐ No ☐

FAMILY MEDICAL HISTORY

Family history details are needed to identify any conditions you may be genetically pre-disposed to. Details as far back as Grandparents are sufficient. Please answer the following:

Please Tick either YES/NO to the following	**YES**	**NO**
1. Has anyone in your family ever had any Heart conditions? *If YES, please state which condition:*	☐	☐
2. Has anyone in your family ever had a stroke? *If YES, please state severity and age:*	☐	☐
3. Has anyone in your family ever had any respiratory problems E.g. Asthma? *If YES, please state which condition:*	☐	☐
4. Has anyone in your family ever had epilepsy? *If YES, please state what kind of epilepsy and what triggered it:*	☐	☐
5. Has anyone in your family ever had significantly high or low blood pressure? *If YES, please state either low or high and if known the reason for this:*	☐	☐
6. Has anyone in your family ever had Bone, Joint or muscular conditions? *If YES, please state which condition:*	☐	☐
7. Has anyone in your family ever had Diabetes? *If YES, please state which Type and if they used medication:*	☐	☐

GP Referral needed?

Yes ☐ No ☐

DECLARATION

I have read, understood and completed the questionnaire and the above information is correct to the best of my knowledge.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

TRAINER NAME: _____ DATE: _____

TRAINER SIGNATURE: _____

I state that I have been informed of the nature of the project and that results of any kind will be kept strictly confidential and I want to be involved. I wish to participate in activities which may include aerobic exercise, resistance exercise and stretching. I realise that my participation in such activities risks the chance of injury. I understand that it is my responsibility to report any symptoms that I may endure. I confirm that I am voluntarily engaging in exercise which has been recommended for me to do.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

TRAINER NAME: _____ DATE: _____

TRAINER SIGNATURE: _____

Data Protection

Any information that has been provided is kept strictly confidential and in adherence with the General Data Protection 2018 Regulation (GDPR) (EU)