

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

NAME DOB..... OCCUPATION.....

ADDRESS

POSTCODE..... CONTACT TELEPHONE No (H)..... (M).....

EMAIL ADDRESS

If you do not wish Venning Fitness to contact you with special offers, educational newsletters or items that could enhance your results please opt out by ticking the box. (All information remains strictly confidential)

If you are over the age of 69 and are not used to regularly activity, please check with your doctor first.

1. Has your doctor ever advised that you have a heart condition, and recommended medically supervised activity only? **Yes** **No**

If yes, please give details.....

2. Have you had chest pain brought on by physical activity in the past few months? **Yes** **No**

If yes, please give details.....

3. Have you ever felt faint or have had spells of dizziness during exercise? **Yes** **No**

If yes, please give details.....

4. Has a doctor ever recommended medication for high blood pressure? **Yes** **No**

If yes, please give details.....

5. Do you suffer from any bone or joint problem that could be aggravated by the proposed activity? **Yes** **No**

If yes, please give details.....

6. Are you currently taking any medication, which your instructor should be made aware of? **Yes** **No**

If yes, please give details.....

7. Are you pregnant or have had a baby in the last six months? **Yes** **No**

Emergency information details

Contact name in case of an emergency?.....

Relationship to you Tel (H) (M).....

Doctors name Surgery Tel

Are you allergic to any drugs? YES NO (If yes please state below)

Do you suffer from: - ASTHMA DIABETES EPILEPSY

Date of last Tetanus injection (if known)

I have read, understood and completed this questionnaire.

Signed

Date

