Pre Activity Readiness Questionnaire

For GV Functional Fitness Studio Personal Training Sessions

Welcome to GV Functional Fitness Personal Training & thank you for taking the time to answer the following questions.

Date: _ _ / _ _ / _ _ _ _

1. PERSONAL DETAILS

Title:______ First Name(s): ______________________________ Surname: ______________________________

Street Address:____

Suburb: ______________________________ State: ____________ Postcode: ____________________________

Phone (h): _________________________ (w): ________________________ (mob): _______________________

Email: _________________________________ Fax: ____________________ D.O.B: _______________________

Person to contact in case of an emergency:________________________Relationship: ______________________

Phone (h): _________________________ (w): _______________________ (mob): ________________________

Your Occupation:____

PRIVACY STATEMENT

The information on this form is collected for the primary purpose of processing your membership. Other purposes of collection include creation of electronic records, attending to administrative matters and corresponding with you. By completing all the questions on this form, GV Functional Fitness is able to process your membership. You have the right to access personal information that GV Functional Fitness holds about you, subject to any exceptions in relevant legislation.

If you wish to seek access to your personal information or enquire about the handling of your personal information, please ask your Personal Trainer. Your information will NEVER be shared with any third party without your prior consent.

Regular communication is an important aspect to our service.

Please tick if you DO NOT consent to receiving email [ ] sms [ ] or telephone [ ] communications from GV Functional Fitness.

GV Functional Fitness always recommends that before you undertake any physical activity, you should first undergo a complete physical examination from a registered medical practitioner, to ensure that you are fit and able to commence your exercise program. You should advise your medical practitioner that the exercise program includes weight lifting, circuit training, aerobic and anaerobic exercise over prolonged periods of time.

CONSULTATION GUIDELINES

Prior to your consultation there are a few guidelines we would encourage you to follow. These guidelines are;

- No **Alcohol** on the day of your consultation (or the day before if attending an early morning consultation).
- Avoid **Smoking** within 4 hours of your consultation.
- Avoid **Eating** within 1 hour of your consultation.
- Be well hydrated, so drink lots of **Water** during the day of your consultation (if you have an early morning appointment, drink lots of water the day prior).

For the consultation;

- Dress should be light and comfortable, e.g. shorts and t-shirt.
- Shoes should be suitable for physical exercise.
- Ensure you have completed the pre-exercise questionnaire.
- Bring your questionnaire along with any additional information you may have that outline any medical and/or injury concerns.
- Ensure you have any of your questions or concerns answered.

2. MEDICAL HISTORY

Regular Doctor's Name: ____ Phone (w): ______________________________

Street Address:____

Suburb: ____ State: ___________________ Postcode: ____________________

How long since your last medical check up? ____

Are you taking any prescription/non-prescription medication? **YES/NO** If yes, please list: ___________________________

____

Have you had any major injuries/surgery during the last three years? **YES/NO** If yes, please list: ______________________

____

Do you have any joint injuries? Do you have any soft tissue injuries (strains, tears, etc.)? If yes, please give details:

____

____

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Please circle YES OR NO for the following questions

Has your Doctor ever said you have bone, joint or muscle problems such as Arthritis that has been aggravated or might be made worse by exercise?	**NO/YES**
Has your Doctor ever said your blood pressure is too high? (eg over 140/95)	**NO/YES**
Have you ever had a heart attack, coronary revascularisation surgery or a stroke?	**NO/ YES**
Has your doctor ever told you that you have heart trouble or vascular disease?	**NO /YES**
Has your doctor ever told you that you have a heart murmur?	**NO /YES**
Do you ever suffer from pains in your chest, especially with exercise?	**NO /YES**
Do you ever get pains in your calves, buttocks or at the back of your legs during exercise, which are not due to soreness or stiffness?	**NO /YES**
Do you ever feel faint or have spells of severe dizziness, particularly with exercise?	**NO /YES**
Do you experience swelling or accumulation of fluid about the ankles?	**NO /YES**
Do you ever get the feeling that your heart is suddenly beating faster, racing or skipping beats, either at rest or during exercise?	**NO /YES**
Do you have chronic obstructive pulmonary disease, interstitial lung disease, or cystic fibrosis?	**NO /YES**
Have you ever had an attack of shortness of breath that developed when you were **not** doing anything strenuous, at any time in the last 12 months?	**NO /YES**
Have you ever had an attack of shortness of breath that developed **after** you stopped exercising, at any time in the last 12 months?	**NO/YES**
Have you ever been woken at night by an attack of shortness of breath, at any time in the last 12 months?	**NO/YES**
Do you have diabetes [IDDM or NIDDM]? If so, do you have trouble controlling your diabetes?	**NO /YES**
Do you have any ulcerated wounds or cuts on your feet that do not seem to heal?	**NO /YES**
Do you have any liver, kidney or thyroid disorders?	**NO /YES**
Do you experience unusual fatigue or shortness of breath with usual activities?	**NO /YES**
Do you have Asthma or any allergies? Please describe:	**NO/YES**
Do you have Epilepsy or similar condition?	**NO /YES**
Are you pregnant? If so, how many weeks?	**NO /YES**

Is there any other physical reason or medical condition, or are you taking any medication(s) which could prevent you from undertaking an exercise program, or that you are concerned about?

Please describe: **NO /YES**

NOTES:
Some of these conditions might include a history of blood clotting, osteoporosis, bone fractures or serious musculoskeletal disorders, or if they have recently lost a large amount of body mass without trying to. Other types of conditions might include psychiatric disorders, later-stage pregnancy or those with a history of health problems during pregnancy. Those people taking medication(s) for medical conditions listed may also need medical clearance.

Please note any injuries/medical condition that may not be outlined above:

If you answered YES to any of the above questions, you will be required to obtain a medical clearance from your Doctor before commencing **ANY** exercise program or fitness assessment.

3. LIFESTYLE

Do you consider your diet to be: GOOD ADEQUATE/APPROPRIATE POOR

Foods you like: ____

Foods you dislike: ____

Your general current eating patterns: ____

____

Are you currently dieting or have special dietary requirements YES/NO, if yes briefly explain: ____________________

____

Average sleep per 24 hours? ____

How do you rate your stress level? **HIGH MODERATE LOW**

Do you smoke? **YES/NO** How many per day? ____

Alcohol Consumption? **YES/NO** Amount and frequency? ____

4. EXERCISE/FITNESS BACKGROUND

When were you in the best shape of your life? ____

How long since you have participated in regular exercise? (maintaining an elevated heart rate for at least 30mins three times/week)

> 12 months 6-12 months 3-6 months < 3 months Currently exercising

____

What type of exercises do you like? ____

What type of exercises do you hate? ____

When did you first start thinking about getting in shape? ____

What has prevented you from reaching your fitness goals in the past? ____

On a scale of 1-10 , how would you rate your present fitness level (1 – worst 10 – best)? ____________________

5. GOALS AND OBJECTIVES

What do you want to achieve from a program of regular exercise?:
(Number in order of priority. 1,2,3, etc)

- To reduce body fat ________
- To improve aerobic capacity (heart/lung fitness) ________
- To improve muscular strength ________
- To improve flexibility ________
- General toning and conditioning ________
- Improve physical wellbeing and quality of life ________
- Reduce stress ________
- Other ____________________ ________
- How will you feel once you have achieved these goals? Be specific? ____________________

What priority does health currently have in your life? Please circle: Low priority Semi High priority

Outline any obstacles, potential actions, behaviours or activities that could limit your progress towards accomplishing your goals (e.g. not training consistently, upcoming holidays, busy time at work, not following the program, allowing other responsibilities to become a priority over exercise etc.). ____

____

To help us tailor an exercise program to your specific needs, please answer the following questions concerning your exercise history.

- While at school did you enjoy participating in sport? Yes ÿ No ÿ
- If 'yes', which sports were your favourites?
- Have you been exercising regularly? Yes ÿ No ÿ
- If you have been exercising regularly, please give details below

Type of exercise: : ______________________________

No. of times per week: : ______________________________

Perceived intensity when exercising:

Hard ÿ

Medium ÿ

Light ÿ

Very light ÿ

- Do you have any negative feelings or have you had any bad experiences with exercise programs? Yes ÿ No ÿ

If 'yes' please briefly explain ____

____

HOW important is it that you achieve these goals?

Extremely **Very Important** **Important** **If it happens,**

WHEN do you want to achieve these goals? ______________________________

Do you have a specific time limit? ______________________________

How many days of the week have you set aside to achieve your goals? ______________________________

Which days of the week are best for you to include exercise? ______________________________

What time of the day do you prefer to exercise? ______________________________

6. TODAY'S MEASUREMENTS AND BASELINE TESTS (Trainer will complete at your assessment)

Girth Measurements	CM	Skin Fold (optional)	MM
Shoulder		Bicep	
Chest		Tricep	
Waist		Sub Scapula	
Hips		Suprailiac	
Thigh		Thigh	
Calf		Calf	
Arms			

Blood Pressure: ______________________ Resting Heart Rate: ____________________

Height: ____________________________ Weight: ______________________________

Other (Trainer may recommend baseline fitness testing, in which case results may be noted below, or attached to this PAQ form)

____

____

7. SURVEY (information provided here helps us to tailor our advertising and services to reach more clients. Thank you)

How did you find us? ____

What made you choose GV Functional Fitness Studio over other services you may have considered?
____

____

What other professional fitness services have you used in the past, and what did you like, and dislike about them? _____________

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8. DECLERATION AND LIABILITY WAIVER

By signing this document, I acknowledge that engaging in any physical activity may carry some risk to my health. I understand that all activities in any fitness program are optional, and I may stop at any time. I **RELEASE GV Functional Fitness Studio**, its directors, servants and agents, personal trainers, staff, and sub contractors from any liability for any loss or injury, which I may suffer whilst participating in any activities howsoever otherwise caused. I have been advised and warned to obtain a wide-ranging and complete physical examination by a registered medical practitioner to confirm that I am fit and able to engage in all of the activities conducted. I agree to disclose any physical limitations, disabilities, ailments, or impairments which may affect my ability to participate in said fitness program herein, and ongoing. I acknowledge that I have read and understood all of the terms and conditions of this agreement prior to me signing the agreement and the information it contains is true and correct. I assume with full knowledge the dangers in my participation in fitness activities and do so at my own risk.

Where the applicant is a minor, this application and agreement must be signed by the minor and his or her guardian, who warrants and agrees by signing this agreement that he or she is authorised to enter into this agreement on behalf of the minor and remains responsible for the minor of all the terms and conditions set out herein, and indemnifies, GV Functional Fitness Studio, its directors, servants and agents, personal trainers, staff and sub contractors, from any claim by the minor.

Signature: ____ **Date: _ _ / _ _ / _ _ _ _**
(If under 16 years old parent/guardian to sign)

Name: ____________________________________ Parent/Guardian's Signature: ________________________________

Trainer's Name: ____________________________________ Trainer's Signature: ________________________________

9. CANCELLATION POLICY

All cancellations must be received at least 24 hours before your training session in order to avoid being charged for your session. Clients who do not cancel with 24 hours notice will be charged for the cancelled session. GV Functional Fitness Studio understands that emergencies happen. We provide every client with one free short-notice cancellation. You will not be charged for your first cancellation with less than 24 hour notice. Subsequent short-notice cancellations will be charged for the session. The free short notice cancellation only applies if GV Functional Fitness Studio is notified prior to the session start time. No-shows are not eligible for the free cancellation.

I have read the above policy and agree to its terms.

Signature: ____ **Date: _ _ / _ _ / _ _ _ _**

GV Functional Fitness will strive to help you reach your health and fitness goals safely and quickly. We aim to establish a long-term supportive relationship with all of our clients. We hope that you feel totally comfortable to make suggestions as to how we might improve our service, at any stage throughout our journey together. We always value your feedback. We look forward to working with you.

10. PHOTO RELEASE PERMISSION

I ______________________________ give permission to GV Functional Fitness to use photographs or video of me for

Promotional material, I also grant permission to be identified by my first and last name.

Signature___________________________________

Thank you for taking the time to complete this form. The information you have provided will help us to provide you with the lifestyle and results you want to achieve.