ROCKET

Personal Training & Group Fitness

Medical Screening Questionnaire

***This form must be completed prior to commencement at Rocket Personal Training**

Personal

Name: (Surname) ______________________________ (Given Name): ______________________________

Sex: ____________________ Date of Birth: ____________________ Age: ____________________

Address (Home): ____

Suburb: ____ Postcode: __________________

Telephone: ______________________________ Work: ______________________________

Email: ____ Mobile: _________________________

Doctor

Name: ____

Address: ____

Suburb: ____ Postcode: __________________

Telephone (Business): __________________________ (After Hours): __________________________

Last Medical Examination: ____

Emergency

In the case of an Emergency, please notify:

Name: ____ Relationship: _____________________

Address (Home): ____

Suburb: ____ Postcode: _______________________

Telephone (Home): _______________________________ Work: _______________________________

Email: ____

Family History

Please identify any health problems that have occurred in your immediate family.

Other: ____

____

Personal Medical History

I have had, or been diagnosed with, or consulted a physician for:

Is there anything you feel we need to know prior to you commencing an exercise program with us?

Condition	***Yes***	***No***	***Relationship to you***	***Present Age***	***Age Onset***	***Fatal – Yes/No***
High Cholesterol						
High Blood Pressure						
Angina						
Heart Attack						
Stroke						
Obesity						
Diabetes						
Asthma						
Cancer						

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Please answer the following questions accurately (If Yes, please give details):

Are you taking any prescribed medications?

____

Condition	***Y/N***	***Condition***	***Y/N***	***Condition***	***Y/N***
Heart Disease		Diabetes		Rheumatic Fever	
High Cholesterol		Epilepsy		Angina	
High Blood Pressure		Cancer		Arthritis	
Stroke		Menstrual Disorders		Chest Pain	
Migraine		Pneumonia		Chronic Headaches	
Asthma		Joint Problems		Bronchitis	

Are you taking any over the counter medications?

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Are you taking / using any other forms of drugs / medications? (Cigarettes and Alcohol included)
Please include amounts (i.e. Cigarettes per day, drinks per day, medications per day).

Activity	***Average Frequency per Week***	***Duration (Hrs.)***	***Exertion Level Easy, Moderate, Hard***	***Length Participation (Mths / Yrs)***

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____

Any major hospitalisations /operations?

____

Current Weight - _______ kg

Do you think your current weight is: Too heavy
Too light
Just right

What do you think your ideal weight is? _______ kg

Do you have trouble controlling your weight and / or diet? Yes / No

Exercise

Please note the activities or sports you do at present e.g. - walking, weights, aerobics, ball sports, swimming, recreational activities etc.

Sleep

How many hours of sleep do you get per night? __________ hrs.

Are you satisfied with this amount? Yes / No

Do you have trouble sleeping? Yes / No

Signed – **Date –**

Thank you for taking the time to complete this questionnaire. The information you have provided will allow us to produce a training schedule that will nest suit you.
If any of this information changes over time, you suffer an injury, or your health deteriorates for any reason please let your trainer know A.S.A.P.