FASTRAK FITNESS

PRE-EMS Activity Questionnaire

Name:_____ D.O.B:_____ Gender: _____

Mailing Address:_____ City:_____ P/Code: _____

Residential Address:_____ City:_____ P/Code: _____

Ph(H):_____ (W):_____ Mob:_____

Email:_____ Occupation: _____

Emergency Contact:_____ Ph(H):_____ (M):_____

PLEASE CIRCLE preferred means of contact: Home Phone, Work Phone, Mobile or Email

Please answer the following questions by circling Yes or No

Do you have family history of (under 60) Heart Disease, Stroke, High Cholesterol or Sudden Death? YES/NO

Are you over 45 & NOT used to vigorous exercise? YES/NO

Are you on any prescribed medications? YES/NO If Yes please list_____

Have you been hospitalized recently? YES/NO If Yes, Condition?_____ When?_____

Have you given birth within the last 12 months? YES/NO If Yes, When?_____ Natural or C-Section? (Please circle)

Are you pregnant? YES/NO Do you have any infections or infectious diseases? YES/NO

Do you have or have you had?

Gout	YES/NO	Glandular Fever	YES/NO	Any heart condition	YES/NO
Stroke	YES/NO	Rheumatic Fever	YES/NO	Heart Murmur	YES/NO
Diabetes	YES/NO	Dizziness or Fainting	YES/NO	High Blood Pressure >140/90	YES/NO
Epilepsy	YES/NO	Stomach or Duodenal Ulcer	YES/NO	Palpitations or Chest pain	YES/NO
Hernia	YES/NO	Liver or Kidney Condition	YES/NO	Raised Cholesterol/Triglycerides	YES/NO

If you answered yes to any of the above questions, please give details of conditions, medications & approximate date cleared:

_____

If you answered YES to any of the above questions, a doctor's clearance is required before commencing an EMS session. Please have your doctor sign below if clearance is not yet obtained. If you have already been cleared by your doctor of the condition please sign below.

Name: **Sign:** **Date:**

Do you have, or have you had?

Arthritis	YES/NO
Asthma	YES/NO
Cramps	YES/NO
Muscular Pain	YES/NO
Do you smoke?	YES/NO

Are you dieting or fasting? YES/NO

Do you have pain or major injuries in the following areas?

Neck	YES/NO	Knees	YES/NO
Back	YES/NO	Ankles	YES/NO
Shoulders	YES/NO	Wrists	YES/NO

If you answered YES to any of the above questions, please give details of condition/s:_____

_____

Are there any reasons which may be a reason to modify your exercise program?_____

What type of exercise have you been doing recently? Exercise Type: _____

Intensity (circle): Hard / Med / Light How long:_____ How often: _____

Please read the following exercise advice carefully:

Make sure you have eaten within 2-3 hours of your training sessions and are well hydrated (drink minimum 05 Lt tepid water or mineral drink 30 mins before training. Training on an empty stomach, with low blood sugar or in a dehydrated state will not allow you to perform at your best. Equally, eating a large or heavy meal just prior to your session should be avoided.

Statement: I recognize that the instructor is not able to provide me with medical advice with regard to my fitness & that the information in this questionnaire is only used as a guideline to enable the instructor to design an appropriate individual fitness program. I have answered the questions above to the best of my ability & understand the advice given.

Signed:_____ **Date:**_____