

# SCREENING QUESTIONNAIRE

Please complete as accurately as possible.

SURNAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: Male/Female (Please Circle)

BLOOD GROUP (If known): \_\_\_\_\_

TELEPHONE: (HM) \_\_\_\_\_ (WK) \_\_\_\_\_ (Mb) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

## 1. FITNESS LEVEL

Please indicate what level of fitness you currently feel you are (please circle):

FIT                                      MODERATELY FIT                                      UNFIT

Please indicate what weight you currently feel you are (please circle):

UNDERWEIGHT                      CORRECT WEIGHT                      SLIGHTLY OVERWEIGHT                      OVERWEIGHT

## 2. SMOKING

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Smoker</b>                     | <input type="checkbox"/> <b>Non Smoker</b>              |
| <input type="checkbox"/> 1 to 5 cigarettes per week        | <input type="checkbox"/> Never Smoked                   |
| <input type="checkbox"/> 1 to 3 per day                    | <input type="checkbox"/> Not smoked for 2 years or more |
| <input type="checkbox"/> 3 to 10 per day                   | <input type="checkbox"/> Not smoked for 1 to 2 years    |
| <input type="checkbox"/> more than 10 ___ (please specify) | <input type="checkbox"/> Not smoked for 1 to 2 months   |

## 3. ALCOHOL

Do you drink alcohol?  Yes                       No  
If you answered Yes, complete the section below, if you answered No, go to question 4.

- |   |  |
|---|--|
| <b>Frequency</b>                              | <b>Quantity</b>                                |
| <input type="checkbox"/> less than 1 day/week | <input type="checkbox"/> 1 to 2 drinks/wk      |
| <input type="checkbox"/> 1-3 days/wk          | <input type="checkbox"/> 2 to 5 drinks/wk      |
| <input type="checkbox"/> 3-5 days/wk          | <input type="checkbox"/> 5-7 drinks/wk         |
| <input type="checkbox"/> more than 5 days/wk  | <input type="checkbox"/> more than 7 drinks/wk |



**4. CAFFEINE**

- Do you drink:       Tea       Coffee       Regular Soft Drinks       Diet Soft Drinks
- Drinks per day?:       1 to 3       1 to 3       1 to 3       1 to 3  
 3 to 6       3 to 6       3 to 6       3 to 6  
 6 to 9       6 to 9       6 to 9       6 to 9  
 10+       10+       10+       10+e

**5. YOUR WEIGHT**

- is stable (*ie has not varied by more than 2kg over the last 12 months*)  
 fluctuates \_\_\_\_\_ (*specify range*)  
 has changed dramatically in the last 12 months  
\_\_\_\_\_ (*specify change*)

**6. PHYSICAL ACTIVITY**

- CURRENTLY ACTIVE** (*please fill out the table below*)

ACTIVITY	TIMES PER WEEK	DURATION	LEVEL OF DIFFICULTY <i>Scale of 1-10</i>

- NOT ACTIVE** If you are not currently active, how long has it been since you were last engaged in rigorous physical activity?
- Less than 6 months  
 6-12 months  
 1-2 years  
 2-5 years  
 More than 5 years \_\_\_\_\_ (*approx number of years*)

**REASON FOR INACTIVITY**

- Ill Health       Lack of Time  
 Pregnancy       Work – demanding/irregular  
 Present or Past Injury       Family Commitments  
 Laziness       No-one to exercise with  
 Cost       Other \_\_\_\_\_ (*specify*)



**7. GOALS**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fat loss         | <input type="checkbox"/> Increased Fitness      | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Injury Rehabilitation  | <input type="checkbox"/> Relieve Boredom   |
| <input type="checkbox"/> Weight gain      | <input type="checkbox"/> Toning & Shaping       | <input type="checkbox"/> Competitive Edge  |
| <input type="checkbox"/> Bulking          | <input type="checkbox"/> Strength & Development |  |
| <input type="checkbox"/> Sports Specific* |   |  |

\*(Specify) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. COMMITMENT**

Please indicate how many times a week you will be able to complete your Programme and approximately how long you will be able to spend at the fitness training facility?

\_\_\_\_\_  
 \_\_\_\_\_

Do you foresee any constraints which may slow or limit your progress?(eg. time limits etc.)

\_\_\_\_\_  
 \_\_\_\_\_

**9. MEDICAL HISTORY**

Please indicate with a tick if you have experienced any of the following:

- High Blood Pressure
- Heart Palpitations
- Fainting or Dizzy Spells
- Chest Pains
- Family History of Heart Disease
- Any Heart Problems
- Diabetes
- Epilepsy
- Asthma
- Gastro-intestinal illness
- Joint or Arthritic Pain
- Headache (severe or frequent)
- High Cholesterol
- Back Injury
- Back Pain (specify ) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Have there been any other illness, medical condition, surgery or operations that you have had that may interfere with your exercise progress? Please give details.

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**10. MEDICATIONS**

Are you currently taking any medication?  Yes  No  
If yes, please give details: \_\_\_\_\_

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IF THERE IS ANY ADDITIONAL INFORMATION NOT ALREADY MENTIONED THAT MAY BE OF ASSISTANCE WHEN YOUR PROGRAMME IS PRESCRIBED? PLEASE GIVE DETAILS BELOW:

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*I agree that the information that I have given in the above screening questionnaire is true and accurate. I also agree that I am in good health, fitness and physical condition to undergo a prescribed exercise program with progressive intensity.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

