



## Medical History

**THIS FORM IS CONFIDENTIAL  
WHEN COMPLETED**

Full Name (please print) .....

1. Are you currently taking prescribed medication? (please circle) YES NO

If you have answered yes to the above, please list .....

2. Are you currently suffering from or have you ever suffered from the following? (please tick)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Trouble           | <input type="checkbox"/> Headaches/Migraines     |
| <input type="checkbox"/> Stomach/Bowel Trouble   | <input type="checkbox"/> Serious Accident        |
| <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Kidney/Bladder Disorder |
| <input type="checkbox"/> Diabetes/Hypoglycaemia  | <input type="checkbox"/> Back/Neck Problems      |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> High Blood Pressure     |
| <input type="checkbox"/> Joint Problems          | <input type="checkbox"/> Jaundice/Hepatitis      |
| <input type="checkbox"/> Severe Stress Reaction  | <input type="checkbox"/> Hernia or Rupture       |
| <input type="checkbox"/> Skin Problems/Allergies | <input type="checkbox"/> Surgical Operations     |
| <input type="checkbox"/> Hearing/Sight Problems  | <input type="checkbox"/> Depression/Anxiety      |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Eating Disorder         |

3. Do you smoke? (please circle) YES / NO

4. What is your weekly alcohol consumption?.....

5. Are you registered as disabled? (please circle) YES / NO If yes, please give further details

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6. Have you had any injuries within the last two years? (please circle) YES / NO If yes, please give further details

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7. Have you had any physiotherapy or doctor intervention for injury in the last 2 years? (please circle) YES / NO  
If yes, please give further details

.....

8. Have you had any operations in the last 2 years? (please circle) YES / NO If yes, please give further details

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### Declaration

The information that I have provided is, to the best of my knowledge both true and accurate. Disclaimer – Innovations Fitness recognises that physical activities which they offer may, in some circumstances create a risk of personal injury. Innovations Fitness goes to reasonable lengths to limit these risks as far as possible. Participants in these activities should be aware of and accept these risks and be responsible for their own actions and involvement.

Signed .....

Full Name (please print) ..... Date .....



## Physical Activity Readiness Questionnaire

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Please complete the necessary details below:

Name: ..... Age:..... Date of Birth:.....

Tel No: ..... Mob No: .....

Address: .....

Emergency contact name and telephone No: ..... E- mail address .....

1. Please read the questions carefully and answer honestly.

### 2. QUESTIONS RELATING TO YOUR MEDICAL HEALTH

**Please Circle**

- |  |     |    |
|--|-----|----|
| a) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?        | Yes | No |
| b) Is your doctor currently prescribing you drugs (for example water pills) for blood pressure or a heart problem?                         | Yes | No |
| c) Do you ever feel pain in your chest when you do physical activities?  | Yes | No |
| d) In the past month have you had chest pain when you are not doing physical activity?   | Yes | No |
| e) Do you ever feel faint or have spells of dizziness?   | Yes | No |
| f) Do you suffer from shortness of breath at any time?   | Yes | No |
| g) If you suffer from asthma, including exercise induced asthma, is there any reason why you should not participate in the activity?       | Yes | No |
| h) Do you have a joint problem (including neck, back or hip problems) that could be made worse by exercise, including jumping and landing? | Yes | No |
| i) Are you aged 60yrs or older?  | Yes | No |
| j) Are you pregnant or have you given birth in the last 6 months?  | Yes | No |
| k) Are you currently taking any medication of which the instructor should be made aware?<br>If so please state reason:                     | Yes | No |
| l) Is there any other reason why you should not participate in physical activity?<br>If so please state:                                   | Yes | No |

3. If you have completed this PAR-Q in advance of the scheduled activity and your health status changes prior to the start of the activity, it is your responsibility to inform the instructor.

4. Your ability to undergo the activity will be monitored during the warm up which will also provide a functional assessment of your ability to proceed.

5. I have read, understood and completed all questions within this questionnaire to my full satisfaction.

6. Are you interested in conducting any further training with Innovations Fitness. If so, would you prefer (please circle).

**Day Sessions**

**Personal Training**

**Weekly Sessions**

Please Sign Here: ..... Print Name: ..... Date: .....

Instructor Sign Here: ..... Print Name: ..... Date: .....