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Pre- AQUACISE / REHAB

Health Screening Questionnaire

Date: DD/MM/YYYY

Name: _____ Cell: | | | | | | | | | | |

Date of Birth: DD/MM/YYYY Age: ___ Height: ___ Weight: ___ Tel: | | | | | | | | | | |

Can you swim? Yes ☐ No ☐ Have you ever had a traumatic experience related to water or swimming? Yes ☐ No ☐ If yes, please explain: _____

In Case of Emergency

Contact: _____Relationship:_____ Phone: | | | | | | | | | | |

Physician _____Specialty: _____ Phone: | | | | | | | | | | |

Please note that if you are NOT used to regular, moderate intensity exercise, you must see your doctor BEFORE enrolling and partaking in the services offered by the Swim Studio CC.

Are you currently under a doctor's care? Yes ☐ No ☐

If yes, explain: _____

When was the last time you had a physical examination? _____

Do you take any medications on a regular basis? Yes ☐ No ☐

If yes, please list medications and reasons for taking: _____

_____

_____

_____

Have you recently (in the past year) been hospitalized? Yes ☐ No ☐

If yes, explain: _____

_____

Have you given birth within the past 6 weeks? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ If yes, how many weeks? ____ When is baby due? __ / __ / ___

Please tick Yes or No and if Yes, please specify:

Heart problems / pains in the chest? Yes ☐ No ☐ _____

Pacemaker? Yes ☐ No ☐ _____

High blood pressure? Yes ☐ No ☐ _____

Low blood pressure? Yes ☐ No ☐ _____

High cholesterol? Yes ☐ No ☐ _____

Blood sugar problems? Yes ☐ No ☐ _____

Diabetes? Yes ☐ No ☐ Type:_____

Lung problems? Asthma? Yes ☐ No ☐ _____

Bronchitis or Emphysema? Yes ☐ No ☐ _____

Unusual shortness of breath? Yes ☐ No ☐ _____

Dizziness or fainting? Yes ☐ No ☐ _____

Ear, nose & throat problems? Yes ☐ No ☐ _____

Arthritis? Yes ☐ No ☐ Type:_____

Osteoporosis? Yes ☐ No ☐ _____

Fibromyalgia? Yes ☐ No ☐ _____

Allergies? Yes ☐ No ☐ _____

Do you require an EpiPen for the allergy? Yes ☐ No ☐ _____

Other metabolic disorders (thyroid, kidney, etc.)? Yes ☐ No ☐ _____

Depression? Yes ☐ No ☐ _____

10-20 kg overweight? Yes ☐ No ☐ _____

Currently on a special diet? Yes ☐ No ☐ _____

Do you smoke? Yes ☐ No ☐ _____

Do you drink alcohol more than three times/week? Yes ☐ No ☐ _____

Do you have parents or siblings who, prior to age 65 have experienced:

A heart attack? Yes ☐ No ☐

A stroke? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐

High cholesterol? Yes ☐ No ☐

Known heart disease? Yes ☐ No ☐

Sudden death? Yes ☐ No ☐

Please tick each one of the following health conditions that apply to you:

☐ Epilepsy ☐ Infections or infectious diseases ☐ Glandular Fever ☐ Rheumatic Fever

☐ Hernia ☐ Liver or kidney condition ☐ Stomach or Duodenal ulcer ☐ Cancer

Please note that if you have ticked any of these, you need to obtain special medical clearance from your doctor to exercise.

This process involves asking your doctor:

1. For clearance to begin exercising
2. What specific restriction, if any, should apply to your condition and which activities and/or exercises you should avoid
3. To identify *when* to exercise in relation to any medication currently being prescribed.

Please sign here if you have already cleared all known conditions with your doctor:

Signature: _____ Date cleared: ____ / ____ / _____

INJURY HISTORY

Please specify procedures done and supply the date if you ever had injury, surgery or joint replacement to any of the following: **Date**

Ankles _____

Knee (R, L) _____

Hip (R, L) _____

Back / spinal disc injury _____

Shoulder (R, L) _____

Neck (such as whiplash) _____

Elbows _____

Wrist _____

Other _____

Please describe any special considerations or how your injury currently affects your ability to function:

_____

_____

_____

EXERCISE & FITNESS HISTORY

1. How would you describe your level of daily activities?

☐ light (office work) ☐ moderate (manual labour) ☐ heavy (construction)

2. Please rate your stress levels by encircling the number (1=low, 5=high):

Physical 1 2 3 4 5 Personal/Emotional 1 2 3 4 5 Mental/Career 1 2 3 4 5

3. Present method of handling stress? _____

_____

4. Number of hours of sleep per night? _____ hours

5. How long has it been since you have exercised regularly (2 or more times/week)? _____

6. What are your current activity patterns?

Intensity: (tick one) ☐ sedentary ☐ moderate ☐ vigorous

History: (tick one) ☐ < 3 months ☐ 3-12 months ☐ 12 months +

7. Would you like to exercise at a moderate or vigorous intensity?

☐ moderate (e.g. a brisk walk) ☐ vigorous (e.g. jogging)

8. Please specify any exercises that are contraindicated or not recommended by your physician or physical therapist? _____

_____

GOALS

1. What are your concerns and goals? (e.g. fat loss, strength, power, muscular endurance, cardio fitness, flexibility, agility, core stability or balance) _____

_____

2. Why do you want to achieve these goals? (e.g. general health, injury prevention, rehab, sport specific training, aesthetic reasons) _____

_____

3. What areas do you want to emphasize or concentrate on? (i.e. specific areas to strengthen, joint stability, cardio or core conditioning) _____

_____

4. Any special considerations or requests? _____

_____

Thank you for completing this questionnaire.