



SYDNEY SURVIVORS 12 WEEKS TO 'A NEW YOU' TRANSFORMATION

PRE-TRANSFORMATION SCREENING FORM

Thank you for taking the time to complete this questionnaire. Please answer each question completely and carefully. This is very important information as it will allow us to assess your suitability to participate and will assist us in providing you with exercise guidance tailored to your individual needs. This information is confidential and will not be released without your written consent.

CLIENT PROFILE		
Surname:	Given Name:	Title:
Male/Female:	D.O.B.:	Age:
Address:		
Suburb:		Postcode:
Home Ph.:		Mobile No.:
Work Ph.:		Email:

EMERGENCY CONTACT DETAILS		
Contact Name:	Relationship:	Ph. No.:

PRE-EXERCISE SCREEN			
Do you have a history of any of the following health conditions?			
Health Condition	Yes	No	If yes, please specify:
Family history of heart disease, stroke, raised cholesterol, or sudden death?	<input type="checkbox"/>	<input type="checkbox"/>	
Low or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition or murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory condition (incl. asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness or fainting?	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis/arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Gout/hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	
Liver/kidney conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Are you, or have you recently had or done any of the following?			
	Yes	No	If yes, please specify:
Are you over 35 (male) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you over 45 (female) and not used to regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently pregnant or have you given birth in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	

