MARGARET RIVER RECREATION CENTRE

Adult Pre-Exercise Screening Tool

OFFICE USE ONLY

Staff ID: _____

Member Details

First Name _____ Surname _____

		RISK FACTORS
Age _____ ☐ Male ☐ Female	≥45yrs Males *or* ≥55yrs Females +1 risk factor	
Family history of heart disease (eg stroke, heart attack) ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	If male <55yrs =+1 risk factor If Female <65yrs =+1 risk factor Maximum of 1 risk factor for this question	
Do you smoke cigarettes? ☐ Yes ☐ No How many per day? _____ Have you tried to quit smoking in the last 6 months? ☐ Yes ☐ No	If yes, (smoke regularly or given up in last 6 months) = +1 risk factor	
Describe your current physical activity/exercise levels? ☐ Sedentary ☐ Light ☐ Moderate ☐ Vigorous Sessions per week _____ Duration of sessions _____	If physical activity level <150min/week = +1 risk factor ≥150min/week = -1 risk factor (vigorous physical activity/ exercise +2 risk factor)	
Please state your Height (cm) _____ Weight (kg) _____	BMI = _____ BMI ≥ 30kg/m2 = +1 risk factor	
Have you been told that you have high blood pressure? ☐ Yes ☐ No	If yes, =+1 risk factor	
Have you been told you have high cholesterol? ☐ Yes ☐ No	If yes, = +1 risk factor	
Have you been told you have high blood sugar? ☐ Yes ☐ No	If yes, = +1 risk factor	
	TOTAL RISK FACTORS =	

Risk Stratification

≥2 Risk Factors – Moderate Risk Clients: Individuals at moderate risk may participate in aerobic physical activity/exercise at a light or moderate intensity (refer to the exercise intensity table). Medical Certificate required.

<2 Risk Factors – Low Risk Clients: Individuals at low risk may participate in aerobic physical activity/exercise up to a vigorous or high intensity (refer to the exercise intensity table).

1) Have you spent time in hospital (including day admission) for any medical condition/illness/injury during the last 12 months?

☐ Yes ☐ No If yes, provide details.

_____

_____

2) Are you currently taking a prescribed medication(s) for any medical conditions?

☐ Yes ☐ No If yes, provide details.

_____

_____

3) Do you have any muscle, bone or joint pain or soreness that is made worse by particular types of activity?

☐ Yes ☐ No If yes, provide details.

_____

_____

Appraisal Information

What do you hope to achieve during your Membership?

☐ Muscle Building ☐ Strength Development ☐ Weight Loss ☐ Injury Rehabilitation
☐ Muscle Toning ☐ Cardiovascular Fitness ☐ Flexibility ☐ Sports Specific Training

What type of activities would you like to include in your program to achieve your goals?

☐ Running/Jogging ☐ Group Fitness Classes ☐ Gym Workouts
☐ Walking ☐ Swimming ☐ Personal Training

Do you often feel tired or stressed?

☐ Always ☐ Mostly ☐ Occasionally ☐ Never

Do you drink alcohol, if so are you a….

☐ Heavy Drinker? ☐ Regular Drinker? ☐ Social Drinker?

How would you rate your current level of fitness?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever worked out in a gym before?

☐ Yes ☐ No

How often do you eat a nutritionally balanced diet?

☐ Always ☐ Frequently ☐ Sometimes ☐ Never

Declaration

I voluntarily submit myself for a series of anatomical and physiological tests. I understand and agree that the Shire of Augusta Margaret River and their respective servants, agents and all others involved, will not be responsible for or under any liability to myself or my estate or dependants arising out of such tests or any injuries sustained by me, including my death.

Signed: _____ **Date:** _____

Print Name: _____