



INVIGORATING WELLNESS

EXERCISE PRE-PARTICIPATION HEALTH SCREENING QUESTIONNAIRE

Name: _____
Email: _____

Date: _____
Contact No.: _____

Step 1:

SYMPTOMS

Does your client experience:

- ☐ Chest pain/discomfort with exertion
- ☐ Difficulty breathing
- ☐ Dizziness, fainting, blackouts
- ☐ Ankle swelling
- ☐ Unpleasant awareness of a forceful, rapid or irregular heart rate
- ☐ Burning/cramping sensations in your lower legs when walking short distance

Yes	No

If you did mark any of the statements under the symptoms, STOP, your client should seek medical clearance before engaging in or resuming exercise. Your client may need to use a facility with medically qualified staff.

If you did not mark any symptoms, continue to steps 2 and 3

Step 2

CURRENT ACTIVITY

Does your client currently perform planned, structured physical activity for at least 30 min, at moderate intensity on at least 3 days, per week for at least the last 3 months?

Yes	No

Step 3

MEDICAL CONDITIONS

Has your client had or do they currently have:

- | | |
|--|---|
| <input type="checkbox"/> a heart attack | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart surgery, cardiac catheterization, | <input type="checkbox"/> hypertension |
| <input type="checkbox"/> or coronary angioplasty | <input type="checkbox"/> cancer |
| <input type="checkbox"/> pacemaker/implantable cardiac | <input type="checkbox"/> lung disease |
| <input type="checkbox"/> defibrillator/rhythm disturbance | <input type="checkbox"/> dyslipidaemia |
| <input type="checkbox"/> heart valve disease | <input type="checkbox"/> metabolic syndrome |
| <input type="checkbox"/> heart failure | <input type="checkbox"/> depression |
| <input type="checkbox"/> congenital heart disease | <input type="checkbox"/> kidney disease |

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