



PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

PERSONAL DETAILS

NAME	PHONE NO/MOBILE NO
ADDRESS	NEXT OF KIN/EMERGENCY CONTACT DETAILS
OCCUPATION	DATE OF BIRTH

FITNESS GOALS

HOW WOULD YOU DESCRIBE YOUR CURRENT FITNESS?	PLEASE DETAIL BELOW	PLEASE TICK WHAT YOU HOPE TO ACHIEVE FROM A FITNESS PROGRAMME	
NEVER EXERCISE		REDUCE BODY FAT	
EXERCISE A LITTLE		IMPROVE AEROBIC FITNESS	
EXERCISE 1 - 2 TIMES A WEEK		LOSE WEIGHT	
EXERCISE IN EXCESS OF 3 TIMES A WEEK		TONE UP	
AT WHAT INTENSITY DO YOU EXERCISE?		REDUCE STRESS	

YOUR HEALTH - Please note, all answers given on this questionnaire are strictly confidential and are only used for the purposes of identifying your exercise needs.

Please give as much information as you can.

Are you currently on medication? please detail		Do you often feel faint or have dizzy spells?	
Do you have a heart condition?		Do you suffer from back or joint pain?	
Have you ever suffered from exercise related chest pain?		Do you have asthma or other respiratory problems?	
Do you suffer from high blood pressure?		Do you have epilepsy?	
Do you suffer from Diabetes?		Do you smoke? If yes, approx how many per day?	
Have you undergone recent surgery?		Are you pregnant or have you given birth in last 6 mths?	
Are you over 65?		Have you ever had a stroke or thrombosis?	

Are there any other reasons, not mentioned above, that may limit, or preclude you from, any exercise programme? Please detail below

I confirm that the above answers are correct to the best of my knowledge. I understand that I should notify a member of Top Body staff in the event of any change in my health as stated above. I accept full responsibility that I am using the gym at my own risk and shall hold the club, its shareholders, directors, officers, employees, representatives and agents harmless from any and all loss, claim, injury, damage or liability sustained or incurred by me resulting therefrom

Signed	Date
Staff Signature	Date