PRE-SCREENING QUESTIONNAIRE: FIRST TIME CLIENTS

Personal Information:

Name: _____ Date of Birth: ____/____/____

Age: _____ Gender: M / F Email: _____

Address: _____City: _____Area Code: _____

Phone: _____ Occupation: _____

Emergency Contact Person: _____Emergency phone: _____

Your relationship to emergency contact: _____

Medical Information

Have you ever had or do you have and of the following? (Please Tick all that apply)

High blood pressure*
Heart/Stroke condition*
Pain/Tightness in the chest*
Dizziness or fainting*
Diabetes
Arthritis
High Cholesterol
Asthma or breathing difficulties
Muscle pain/cramps
Epilepsy
Back pain
Joint pain

If you answered YES to any of the above please provide details:

_____
_____
_____

If you have answered YES to two or more of the above cardiac risk factors in red, then you should see a doctor for a medical clearance before starting the Boot Camp Programme.

Do you have any injuries that may hinder your participation in the boot camp? Yes / No

If you answered yes to the previous question, please describe the injury:

_____
_____
_____

Have you exercised in the water before? Yes/No

If you have answered no, are you comfortable to participate in the Water sessions?
Yes / No

Do you smoke? **Yes / No**

If no, have you quit in the last two years? **Yes / No**

Is there anything that we should know that may limit your activity or participation on our Boot Camp Programme? **Yes / No**

If yes, please specify:

_____

Are you currently taking medication? **Yes / No**

If yes, what is the medication you are taking?

_____

Has a doctor imposed any activity restrictions? If so, please describe:

_____

_____

_____

Exercise and Diet

Do you engage in regular exercise/sport? **Yes / No**

If yes, describe the nature of the programme. E.g. cardiovascular, weight programme

_____

_____

What are your goals out of this boot camp? (Please Tick which ones apply)

Body fat reduction
Cardiovascular fitness
Muscular strength
General Wellbeing
Muscular Definition
Increased flexibility
Social
Try something new
Weight loss
Other (Please specify): _____

How many sessions do you aim to attend? (Per week) _____

What is your short term goal? (8 weeks)

_____

_____

_____

Overall how would you describe your nutritional intake? (Please circle one only)

Poor Average Good Excellent

If your attendance becomes irregular and you don't make your session per week goal, do you give us permission to contact you to offer support? Yes / No

If there is any other information you think we should know please use the space below:

_____
_____
_____
_____

I have answered all questions honestly and completely to the best of my ability.

Participant Signature: _____ **Date:** _____