



## PRE-SCREENING QUESTIONNAIRE

### Personal Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Age: \_\_\_\_\_ Gender: M / F Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Area Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_ Emergency phone: \_\_\_\_\_  
Relationship to emergency contact: \_\_\_\_\_

### Medical Information

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

High blood pressure*	High Cholesterol
Heart/Stroke condition*	Asthma or breathing difficulties
Pain/Tightness in the Chest*	Muscle pain/Cramps
Dizziness or fainting*	Epilepsy
Diabetes	Back pain
Arthritis	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 a family history of heart disease, stroke or raised cholesterol of relatives under the age of 65? Yes / No**

If you have answered yes, 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

**Have you had surgery in the last year? Yes / No**

Please specify \_\_\_\_\_

**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 medication are you taking? \_\_\_\_\_

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

\_\_\_\_\_

**Please indicate any other medical conditions or activity restrictions that you may have. It is important that this information be as accurate and complete as possible.**

\_\_\_\_\_

### **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 Name:** \_\_\_\_\_

**Participant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_