Top Body
Strength & Fitness

Fitness & Health Questionnaire

Name: Phone/Mobile No.
Address: Postcode:
Age: Occupation:

Next of Kin/Emergency Contact Details:

HEALTH QUESTIONS

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.

Do you have a heart condition?...Y / N

Have you ever suffered from exercise related chest pain?.....Y/ N

Do you suffer from high blood pressure?.....Y / N

Do you suffer from Diabetes.....Y. / N

Have you undergone recent surgery?.....Y / N

Are you over 65?.....Y../ N

Do you often feel faint or have dizzy spells?.....Y / N

Do you suffer from joint or back pain?.....Y / N

Do you have asthma or other respiratory problems?.....Y / N

Do you have epilepsy?.....Y./ N

Do you Smoke.....Y/ N If yes, approx how many per day? .....

Are you pregnant or have you given birth in the last 6 months.....Y / N

Have you ever had a stroke or thrombosis.....Y / N

Are you currently taking medication? If yes please detail:

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If you have answered YES to any of the above questions, please write full details here:

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: **Member Number:**