

ELITE BOOTCAMP TRAINING – HEALTH FORM

Self Assessment & Additional Information:

* First and Last Name _____

I rate my current fitness level as a (1-5), five being high.

1 2 3 4 5

* Name of Emergency Contact

* Number of Emergency Contact

* Who are the Top 3 People You admire the most, excluding your Dad or Mom.

* What makes you tick..? (What are you passionate about?)

Please answer the following four questions truthfully. Explain any medications, conditions or injuries in the field boxes below.

* Are you currently taking any medications?

* Do you have any medical conditions that may preclude you from participating in rigorous physical activities?

* Do you suffer from any diseases such as Diabetes, Liver, Lung, Heart or Kidney disease?

* Do you have any physical conditions or previous injuries that may preclude you from participating in rigorous physical activities?

Medical History and Present Medical Condition

* Major Coronary Risk Factors

*All the questions in this questionnaire are relevant and MUST be answered to complete.

*Are you aware of any of the following?

Warning: If you answer yes to two or more of the following questions, it is highly recommended that you undertake a medical examination before beginning a vigorous exercise program.

	Yes	No
Q1 Has your doctor said you have high blood pressure?	<input type="radio"/>	<input type="radio"/>
Q2 Has your doctor said you have high cholesterol?	<input type="radio"/>	<input type="radio"/>
Q3 Do you have diabetes?	<input type="radio"/>	<input type="radio"/>
Q4 Do you smoke cigarettes?	<input type="radio"/>	<input type="radio"/>
Q5 Do you have a family history of heart problems or coronary disease in parents or siblings prior to age 55?	<input type="radio"/>	<input type="radio"/>

*

Major symptoms or signs of cardiopulmonary or metabolic disease

*All the questions in this questionnaire are relevant and MUST be answered to complete and save the section.

*Do you experience any of the following?

Warning: If you answer yes to any of the following it is suggested that you undertake a medical examination before beginning a vigorous exercise program.

	Yes	No
Q1 Pains in your heart or chest?	<input type="radio"/>	<input type="radio"/>
Q2 Shortness of breath with mild exertion?	<input type="radio"/>	<input type="radio"/>
Q3 Dizziness or fainting?	<input type="radio"/>	<input type="radio"/>
Q4 Sudden painful or difficult breathing at night?	<input type="radio"/>	<input type="radio"/>
Q5 Ankle swelling?	<input type="radio"/>	<input type="radio"/>
Q6 Palpitations or heart irregularities?	<input type="radio"/>	<input type="radio"/>
Q7 Claudication (lameness, limping)?	<input type="radio"/>	<input type="radio"/>
Q8 A known heart murmur?	<input type="radio"/>	<input type="radio"/>

Historic conditions or diseases

Please ensure that you read all questions and provide answers for those that are relevant to you

Q1 Please tick any conditions you have or have had in the past.

- Heart Attack
- Stroke
- Diabetes
- Chest Discomfort
- Stomach or intestinal problems
- Arthritis
- Osteoporosis
- Migraine or recurrent headaches
- Thyroid disorder
- Trouble Sleeping
- Broken Bones
- Cancer
- Swollen, stiff, or painful joints
- Hernia

Q2 If you chose swollen, stiff, or painful joints, which joints?

Q3 If you ticked anything in question 1, please explain here:

Q4 Please list any prescribed medications you are now taking:

Q5 Please list any other over the counter medications or dietary supplements you are now taking:

Q6 Please list any illness, hospitalisations, or surgical procedure within the last 2 years:

Regular Exercise

Please ensure that you read all questions and provide answers for those that are relevant to you

	Nope, sorry	Sometimes	I love this activity
Are you presently involved in regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cycling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racquet Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aerobics Classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circuit Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you!