

Pre-Exercise Screening Form



APPROVED AND RECOMMENDED BY THE NZ REGISTER OF EXERCISE PROFESSIONALS (REPs). To be used in conjunction with the REPs New Zealand Pre-Screening Guide and associated risk stratification best practice. For use exclusively for REPs Registered Exercise Professionals only.

Name:	Age:
Medical Provider(s) Name and Contact:	

SECTION 1 : IMPORTANT MEDICAL INFORMATION

	YES	NO
CARDIOVASCULAR AND PULMONARY CONDITIONS*: Diagnosed heart condition or stroke, or unreasonable leg or chest pain during exercise? Blood pressure over 200/110mm/Hg (measured at time of this pre-screen)? Diagnosed pulmonary disease? (Exercise Professional - see note 1 below) IF YOU TICK YES TO THIS QUESTION PROCEED ONLY UNDER MEDICAL GUIDANCE		

IF YOU TICK YES TO 2 OR MORE OF THE FOLLOWING QUESTIONS, THEN PROCEED WITH CAUTION UNDER GUIDANCE

	YES	NO
FAMILY HISTORY: Father or brother under 55 years with a history of heart disease or stroke? Mother or sister under 65 years with a history of heart disease or stroke?		
AGE: Male over 45 years? Female over 55 years?		
BLOOD PRESSURE: Over 140mm/Hg systolic or 90mm/Hg diastolic. Or, on blood pressure medication?		
ASTHMA: Attack that required medical attention last 12 months?		
SMOKING: Currently or quit within previous 6 months?		
GENERAL ACTIVITY LEVEL: Currently sedentary?		
BODY COMPOSITION (INDICATIVE): BMI \geq 30 kg/m ² or Waist (cm) \div Height (cm) ratio above 0.6?		
BONE AND JOINT: Known bone or joint problem that could be aggravated by exercise?		
OTHER: Any other condition that may increase risk of adverse reaction to exercise?		
OPTIONAL	LIPIDS: Identified blood lipids outside recommended range (Exercise professional see note 2 below):	
	GLYCEMIC CONTROL: Diagnosed Type 1 or 2 diabetes (Exercise Professional - see note 3 below)	

NOTES FOR EXERCISE PROFESSIONAL

1) Cardiovascular / pulmonary disorder

Angina
 Shortness of breath with mild exertion or during sleep (Dyspnea)
 Dizziness during exercise (Syncope)
 Ankle swelling (Edema)
 Heart murmur
 Unpleasant, rapid beating of heart (Palpitations / Tachycardia)
 Intermittent claudication (Cramping/pain in legs unexplained)
 Pulmonary disorder such as COPD, cystic fibrosis, emphysema, other

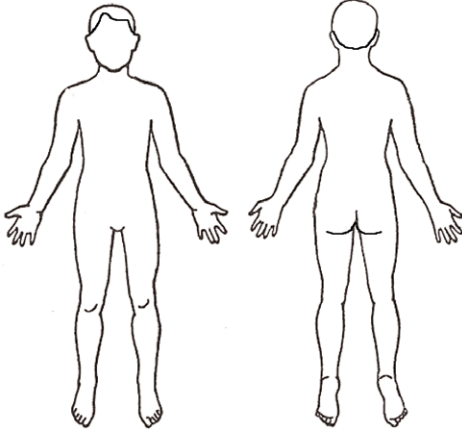
2) Dyslipidemia. Known result or measured at time of pre-screen:

LDL \geq 3.37 mmol/L
 Total \geq 5.18 mmol/L
 HDL $<$ 1.04 mmol/L
 Triglycerides (TG) \geq 1.7 mmol/L
 TG/HDL ratio \geq 4.0

3) Glycemic control. Known result or measured at time of pre-screen:

Glucose \geq 5.5 mmol/L over several readings
 HbA1c \geq 40 mmol/mol

SECTION 2 : OTHER IMPORTANT CONDITIONS

<p>MUSCULOSKELETAL</p> <p>Any pain or major injury to: (Please tick any which apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Feet / Ankles <input type="checkbox"/> Calf / Shin <input type="checkbox"/> Knees <input type="checkbox"/> Hamstrings <input type="checkbox"/> Hips / Groin <input type="checkbox"/> Lower Back / Abs <input type="checkbox"/> Upper back / Ribs <input type="checkbox"/> Neck / Shoulders <input type="checkbox"/> Arm / Elbow <input type="checkbox"/> Wrists / Hands 	<p>Please circle any area that may be adversely affected by exercise:</p> <div style="text-align: center;">  </div>
<p><input type="checkbox"/> PREGNANT now or in last 12 months</p>	
<p><input type="checkbox"/> EPILEPSY</p>	
<p><input type="checkbox"/> ARTHRITIS</p>	
<p>MEDICATIONS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Beta blockers <input type="checkbox"/> ACE inhibitors <input type="checkbox"/> Diuretic <input type="checkbox"/> Statin <input type="checkbox"/> Oral hypoglycemic <input type="checkbox"/> Other 	

NOTES: _____

Thank you for taking the time to answer the questions above. Your answers will help your REPs Registered Exercise Professional determine the best approach to help you reach your exercise goals.

Informed Consent

I acknowledge that that information provided above regarding my health and personal information is, to the best of my knowledge, correct.

I will inform my exercise professional immediately if there are any changes in my health status.

I understand that participating in physical activity and exercise can carry a risk, and I accept all responsibility for that risk.

I understand that due care will be undertaken by my REPs Registered Exercise Professional at all times.

NAME: _____

SIGNATURE: _____

DATE: _____ / _____ / _____

SECTION 3 : PROGRAMMING INFORMATION

EXERCISE GOALS

<input type="radio"/> Strength	NOTES
<input type="radio"/> Muscle mass increase	
<input type="radio"/> Lose bodyfat	
<input type="radio"/> Gain aerobic fitness	
<input type="radio"/> Flexibility	
<input type="radio"/> General health	
<input type="radio"/> General energy	
<input type="radio"/> Sport specific (speed etc)	

EXERCISE HISTORY

CURRENT OR VERY RECENT:	NOTES
<input type="radio"/> Resistance/weight training	
<input type="radio"/> Structured aerobic exercise	
<input type="radio"/> Group exercise	
<input type="radio"/> Regular sport or recreation	
<input type="radio"/> General activity	
<input type="radio"/> Other	
<input type="radio"/> Prior exercise facility membership(s)? Reason for stopping?	

AVAILABILITY

List preferred timeslots (if any) and preferred maximum duration:

	MON	TUE	WED	THU	FRI	SAT	SUN
MORNING							
LUNCH							
AFTERNOON							
EVENING							

EXERCISE PREFERENCES

What type of exercise(s) enjoyed previously?

What type of exercise(s) disliked previously?

SECTION 4 : MONITORING PROGRESSION

	RESULT	GOALS		
		By:	By:	By:
MOVEMENT COMPETENCY				
Squat both legs				
Squat single leg				
Deadlift				
Lunge				
Row				
Press				
STRENGTH				
Exercise 1:				
Estimated 1 RM				
Reps completed				
Load used				
Exercise 2:				
Estimated 1 RM				
Reps completed				
Load used				
BODY COMPOSITION				
Weight				
Height				
Waist				
BMI				
Waist / Height Ratio				
Estimated % fat				
Estimated % LMM				
Sum ____ skinfolds				
Girths:				
AEROBIC				
Blood pressure Systolic/Diastolic				
Estimated VO2 max				
HR steady state				
Workload				
FLEXIBILITY				
Other				

PROPOSED SCHEDULE:	Based on availability, assessment results and goals:						
	MON	TUE	WED	THU	FRI	SAT	SUN
MORNING							
LUNCH							
AFTERNOON							
EVENING							