Kate O'Connell M Phty B Sc (Sp St)

Strength and Conditioning Questionnaire

NAME:

DOB:

CONTACT NUMBER:

Goals of strength & conditioning program/timeframes

(eg. Events, season dates)

(if unsure, can discuss during session)

1.

2.

3.

Available equipment/setting

(Equipment examples: machine weights, barbell, dumbbells, Swiss balls, medicine balls, Setting: gym/recreation centre/home/local sporting oval/park)

_____
_____
_____
_____

Current exercise/routine

(Please attach current program if applicable)

- Type (eg walk/swim/run):
- Intensity (distance/time):
- Frequency:
- Supervised/unsupervised:
- If supervised; contact details (eg. PT/coach):

General health

Do you have any general health concerns which may impact on your ability to perform a prescribed strength and conditioning program, or should be considered?

YES/NO

Details:

_____
_____
_____

Pre-exercise screening questionnaire

(Adapted from Sports Medicine Australia's pre-exercise screening questionnaire (2005))

Have you ever had a heart attack, coronary revascularisation surgery or a stroke?	No	Yes
Has your doctor ever told you that you have heart trouble or vascular disease?	No	Yes
Has your doctor ever told you that you have heart trouble or vascular disease??	No	Yes
Do you ever suffer from pains in your chest, especially with exercise?	No	Yes
Do you ever feel faint or have spells of severe dizziness, particularly with exercise?	No	Yes
Do you experience swelling or accumulation of fluid about the ankles?	No	Yes
Do you ever get the feeling that your heart is suddenly beating faster, racing or skipping beats, either at rest or during exercise?	No	Yes
Do you have chronic obstructive pulmonary disease, interstitial lung disease, or cystic fibrosis?	No	Yes
Have you ever had an attack of shortness of breath that developed when you were not doing anything strenuous, at any time in the last 12 months?	No	Yes
Have you ever had an attack of shortness of breath that developed after you stopped exercising, at any time in the last 12 months?	No	Yes
Have you ever been woken at night by an attack of shortness of breath, at any time in the last 12 months?	No	Yes
Do you have diabetes [IDDM or NIDDM]? If so, do you have trouble controlling your diabetes?	No	Yes
Do you have any ulcerated wounds or cuts on your feet that do not seem to heal?	No	Yes
Do you have any liver, kidney or thyroid disorders?	No	Yes
Do you experience unusual fatigue or shortness of breath with usual activities?	No	Yes
Is there any other physical reason or medical condition, or are you taking any medication(s) which could prevent you from undertaking an exercise program, or that you are concerned about?	No	Yes

Disclaimer/ Statement

I acknowledge the practitioners' advice given to me is not to be treated as medical advice, only as a guideline. All clients must be aware of their respective physical conditions, levels and limits. They must understand that there are risks and limitations associated with their participation and make their practitioner aware of any injuries, illnesses etc that may impact upon exercise.

South Melbourne Physiotherapy's practitioners cannot be held responsible for any harm to the individual during the participation of exercise.

All information provided by the individual is private and confidential and will only be used by South Melbourne Physiotherapy where it is necessary for the benefit of the individual.

South Melbourne Physiotherapy supports all individual's rights to privacy in relation to this information and handles it in accordance with legal requirements.

I have understood and answered all of the above questions truthfully and to the best of my ability.

*Client signature*_____ *Date:*_____

*Practitioner signature*_____ *Date:*_____