PRE-EXERCISE QUESTIONNAIRE

2 WEEK GROUP FITNESS TRIAL

T's & C's
Must show proof of local residency
Valid only for group fitness classes during staffed hours
PEQ to be completed & presented at Your Fitness reception to validate trial

Name: _____ Phone: _____

Address: _____

Occupation: _____ DOB: ____/____/_____ Sex: M/F

Email Address: _____

How did you hear about Your Fitness: _____

Do you smoke or consume alcohol? Please specify amount & regularity:

_____

When was your last medical examination? _____

Specify any injury, illness or major surgery: _____

Do you suffer from (Please tick to indicate "yes"):

☐ Low blood pressure	☐ High blood pressure	☐ Heart Condition
☐ Asthma	☐ Low blood sugar	☐ Diabetes
☐ Epilepsy	☐ Joint/Muscle Pain	☐ Current Injury
☐ Recent Hospitalisation	☐ Other, specify _____	

Are you pregnant (current or recent) Y/N. Please Specify _____

Are you on any medication? _____

If you have indicated yes to any of the above conditions, have you had a clearance from your doctor to exercise (if no you may be asked to provide a medical certificate before exercising)? ☐ Yes ☐ No

General Release

It is my expressed intent on signing this to release Your Fitness, its officers, directors, owners, heirs & assigns from any and all claims for personal or general liability which may arise as a result of my participation, whether "fault" may be attributed to myself or its employees. I also understand that each member and guest shall be liable for any property damage and or personal injury occurring at Your Fitness.

Members Signature: _____ Date: ____/____/_____