



# Physical Readiness Questionnaire

Thank you for watching our induction video. Please complete this form.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Has it been recommended by a doctor that you should only pursue an exercise plan that is certified suitable by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had surgery in the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last six months have you experienced any chest pain?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any of the following? (tick all that apply)  |                          |                          |
| <input type="checkbox"/> A heart condition  |                          |                          |
| <input type="checkbox"/> Severe headaches/dizziness   |                          |                          |
| <input type="checkbox"/> Backpain   |                          |                          |
| <input type="checkbox"/> High/low blood pressure  |                          |                          |
| <input type="checkbox"/> Asthma   |                          |                          |
| <input type="checkbox"/> Epilepsy   |                          |                          |
| <input type="checkbox"/> Diabetes   |                          |                          |
| <input type="checkbox"/> Bone/joint/muscle problems   |                          |                          |
| <input type="checkbox"/> Allergies  |                          |                          |
| <input type="checkbox"/> Current or recent injuries   |                          |                          |
| 5. Are you pregnant or have recently given birth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking any prescribed medication or drugs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there any other reason, not mentioned here, why you should not follow a graduated exercise programme?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is there any other illness we need to know about?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. If yes, what do we need to know?   |                          |                          |

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Full name

\_\_\_\_\_

Email

Tel:

Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of birth

Date

Signature

\_\_\_\_\_

**Please bring this form to the gym when you first start**

 For information on how we use personal information please go to the Privacy Statement on our website [www.bolsover.gov.uk](http://www.bolsover.gov.uk)