

CLIENT PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

DATA PROTECTION DECLARATION

Effective Fitness Now needs to have certain personal medical and fitness information about clients to ensure that we act consistently with the duty of care owed. All information will be held in confidence and in accordance with the Data Protection Act 1998. Agreement to the providing of the required personal data is a condition of acceptance onto this course. Please note that sensitive Personal Data (as defined under the Act) will not be disclosed without your specific consent. Information will not be released to third parties for marketing purposes.

Name		Age	
Date			

INJURIES / MEDICATION

Have you ever been diagnosed as having, currently experiencing, or on medication for the following:

- | | |
|--|---------------------------------|
| <input type="checkbox"/> Back Injury | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Any Head / Neck Injury | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Knee / Leg / Foot Injury | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Arm / Wrist / Hand Injury | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Hernia | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Hip Trouble | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Heart Condition | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Angina | Currently / Date Diagnosed..... |
| <input type="checkbox"/> High Blood Pressure | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Asthma | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Bronchitis | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Arthritis | Currently / Date Diagnosed..... |
| <input type="checkbox"/> Sickle-cell disease / anaemia | Currently / Date Diagnosed..... |

DO YOU CURRENTLY HAVE:

- A cold / flu
- Sore throat
- Any aches and pains in your limbs
- Are you currently under any medication: **Yes / No** If yes please indicate what medication and for what ailment below.

- Are you pregnant? **Yes / No.**
- Do you wear contact-lenses: **Yes / No.**
- If there is anything that you feel we should be made aware of that may compromise your health, safety and welfare on this training course please highlight this below:

DECLARATION:

I declare that I have answered all of the above questions accurately, I am fit and able to undertake the training and that it is my responsibility to make the instructors aware of any medical condition / ailment / and medication that is current.

Name:.....

Signed:.....

Date:.....