

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

For most people an increase in physical activity is beneficial. This questionnaire is designed to identify anyone for whom an increase in physical activity may be inappropriate or they may need to seek medical guidance before taking part in a new activity.

Please answer YES or NO to the following questions:

|  |  |  |
| --- | --- | --- |
| 1. Have you had a diagnosis of/treatment for a heart condition (heart disease/stroke/heart attack etc)?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Do you ever feel pain in your chest when you do physical activity?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Have you ever had chest pain when you are not doing physical activity?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Do you have shortness of breath at rest?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Have you had a diagnosis of/treatment for high blood pressure?
 | Yes [ ]  | No [ ]  |
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| 1. Do you ever feel faint or have spells of dizziness?
 | Yes [ ]  | No [ ]  |
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| 1. Do you have a joint problem that could be made worse by exercise?
 | Yes [ ]  | No [ ]  |
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| 1. Do you currently have pain or swelling in any part of your body (such as from injury, acute flare-up of arthritis, or back pain) that affects your ability to be physically active?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Has a health care provider told you that you should avoid or modify certain types of physical activity?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Do you have any other medical or physical condition (such as diabetes, cancer, osteoporosis, asthma, spinal cord injury, recent operation) that may affect your ability to be physically active?
 | Yes [ ]  | No [ ]  |
|  |  |  |
| 1. Are you currently taking any medication of which the instructor should be made aware?
 | Yes [ ]  | No [ ]  |
|  If YES please detail:       |  |  |
|  |  |  |
| 1. Is there any other reason why you should not participate in physical activity?
 | Yes [ ]  | No [ ]  |
|  If YES please detail:      |  |  |
|  |  |  |
| 1. What date did you give birth?
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|  |
| 1. Did you have a vaginal or caesarean birth?
 | Vaginal [ ]  | Caesarean [ ]  |
|  |
| 1. At your post birth check up did your doctor have any concerns regarding you starting exercising?

If YES please detail:      | Yes [ ]  | No [ ]  |

IF YOU HAVE ANSWERED YES TO ONE OR MORE QUESTIONS

Please talk to your doctor by phone or in person before starting Pilates. Tell your doctor about the questionnaire and which question(s) you answered YES to. Please follow your doctors’ guidance. You may still be able to participate in Pilates as long as you build up slowly and gradually or you may need to modify some Pilates movements to ensure it is safe for you.

IF YOU HAVE ANSWERED NO TO ALL QUESTIONS

You can be reasonably assured that you are ready to start Pilates. Please remember to begin slowly and build up gradually.

PLEASE NOTE

If your health changes so that subsequently you answer YES to any of the above questions, please inform your instructor and seek the necessary guidance from your doctor should you wish to continue participating in Pilates.

If you feel unwell because of a temporary illness, such as a cold or flu, please do not participate in a class until you are well again.

CURRENT PHYSICAL ACTIVITY

Please detail any physical activity you regularly participate in, for example fitness classes, walking, running:

|  |  |
| --- | --- |
| ACTIVITY | HOURS PER WEEK |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

Please detail your reason or motivation for joining a Pilates class:

VIRTUAL CLASSES

If I participate in virtual classes I accept responsibility for my own body. I will follow the verbal and visual instructions. I acknowledge that the teacher is unable to see what I am doing and can’t offer me advice if I am not doing an exercise correctly [ ]

CONTACT DETAILS

Name:

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Address:

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Contact Number:

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Date of Birth:

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Emergency

Contact Name:

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Emergency

Contact Number:

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Relationship to

Emergency Contact:

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|  |

Email Address:

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I consent to being contacted by Pink Acorn Wellness regarding Pilates class information via phone call, text message or email [ ]

I consent to receiving promotional information from Pink Acorn Wellness via email [ ]

DECLARATION

If I bring a child to the class I agree I am responsible for their welfare and safety [ ]

I consent to photos taken in class of myself and child to be used on the Pink Acorn Wellness website, Facebook page and Instagram page [ ]

To the best of my knowledge, all of the information I have provided on this questionnaire is correct. If my health changes, I will complete this questionnaire again. If I have answered YES to any of the questions, I have gained the required consent/advice to participate in Pilates.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |       | Date: |       |

You will be asked to complete this questionnaire every 6 months to ensure the data is up to date. You can request to review your data at any time.

REVIEW

I have reviewed the document and confirm no details have changed

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| --- | --- | --- | --- |
| Signed: |       | Date: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |       | Date: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |       | Date: |       |