



Physical Activity Health Questionnaire

Please answer the questions below:-

1	Have you sought medical advice for a heart condition?		Yes / No
2	Do you experience chest pains?		Yes / No
3	In the past month have you had a pain in your chest when you were not doing physical activity?		Yes / No
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		Yes / No
5	Do you have a bone or joint problem?		Yes / No
6	Do you have low or high blood pressure?		Yes / No
7	Are you pregnant?		Yes / No
8	Are you diabetic?		Yes / No
9	Are you asthmatic?		Yes / No
10	Are you over 60 years of age?		Yes / No
11	Have you had an injury in the last 6 months?		Yes / No
12	Do you know of any reason why you should not increase your physical activity?		Yes / No
I understand that if I answered YES to one or more of the above questions, I should seek medical advice before undertaking any SCT activities.			

PLEASE ADVISE THE COACHES OF ANY OTHER CONDITIONS YOU FEEL THEY MIGHT NEED TO KNOW ABOUT OR ANY CHANGES TO CIRCUMSTANCES

*** This information will be kept for SCT health records only.**

I understand that this information will be shared with other SCT coaches.

Signed.....

Name (please print).....

Date.....