



## Athlete Pre-Screening Questionnaire

Name	<input type="text"/>	Surname	<input type="text"/>
DOB	<input type="text"/>	Gender	<input type="text"/>
Address	<input type="text"/> <input type="text"/>		
Postcode	<input type="text"/>	Contact number	<input type="text"/>
Email	<input type="text"/>		

### Emergency Contact

Name	<input type="text"/>
Relationship	<input type="text"/>
Contact number	<input type="text"/>
Email Address	<input type="text"/>

### Supervised Session times

Monday	18:30 - 20:30
Tuesday	17:00 - 19:00
Wednesday	16:30 - 18:30
Friday	16:30 - 19:30

Please note that direct supervision will be provided at these times. However, the programmed sessions can be completed at any time that suits each athlete.

### Payment

The cost of the programme is £48 per month. Payment is due on the 1st of each month and should be paid into the following account.

Name: AE Gyms Ltd  
Bank: Bank of Scotland

Sort: 80-22-60  
Account: 18052061

**Please tick all statements that apply to you.**

Yes

<input type="checkbox"/>

1. Have you ever suffered or been told by a doctor that you have suffered a stroke?
2. Has your doctor ever told you that you have a heart condition?
3. Do you ever experience unexplained pains in your chest at rest or during physical activity?
4. Do you ever feel faint or have dizzy spells during exercise that cause you to lose balance?
5. Have you had a asthma attack requiring medical attention in the last 12 months
6. Do you have diabetes (type I or type II)
7. Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity?
8. Do you take regular prescribed medication?
9. Do you have high/low blood pressure
10. Do you have a allergies that require you to carry an epipen?
11. Do you have any muscle or joint conditions, which may be made worse with physical activity
12. Are there any other medical conditions, which could affect your ability to perform physical activity?

If you answered yes to any of the above, then please give details below

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### Training History

Number of sessions per week

Duration of each session (hrs)

Primary Sport(s)

**No** **Very experienced**  
**experience**

How would you rate your previous weight lifting experience?

1	2	3	4	5
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Core lifts (Deadlift, Squat, Bench press, Shoulder press, Bent over row, Pullups)

1	2	3	4	5
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Olympic lifts (Clean & Jerk, Snatch)

1	2	3	4	5
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### Parent/Guardian Consent

Name

Tel

Surname

Email

I confirm that my son/daughter is physically able to participate in the Athlete Development Programme and has my permission to do so. I also give Athletic Edge permission to take photo/videos of my son/daughter to aid the coaching process.

Signed