EMS Training Participant Questionnaire

Full name: .....

Address: .....

Tel.: .....

e-mail: .....

Date of birth: ..... Height (cm): ..... Weight (kg): .....

Alternative contact: .....

Questions about health (circle the right answer):

Have you ever been diagnosed with cardiological problems?	YES/NO
Do you have an artificial pacemaker?	YES/NO
Do you experience chest pain during exercise?	YES/NO
Have you ever had an epilepsy attack?	YES/NO
Have you had any surgeries in the past 3 months?	YES/NO
Have you ever been diagnosed with cancer?	YES/NO
Can your health/medical condition cause any pain or limitations that need to be taken into consideration during your training programming?	YES/NO
Do you have any injuries or orthopedic problems?	YES/NO
Do you have any skin damage (wounds, burns, etc.) on your body?	YES/NO
Are there any other medical diseases/contraindications that your trainer should know about?	YES/NO

If you answered one or more questions "YES", please specify:

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Do you regularly take any medications?	YES/NO
If so, does it affect your ability to exercise?	YES/NO
Are you pregnant?	YES/NO
Are you currently breast feeding?	YES/NO

What is your training goal? .....

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How did you find out about our studio? .....

I declare that all information provided above is true and correct. I am aware of the fact that the trainer will not be held responsible in the event of an injury or accident caused by EMS Training due to false information provided in the medical questionnaire.

Date: ..... Participant's signature: .....