

RETURN TO TRAINING QUESTIONNAIRE



Name:

Date Stopped Training at Gymnastics Centre:

Week	Approximate Hours Per Week	Cardio Work (Hours Total)
March 23		
March 30		
April 6		
April 13		
April 20		
April 27		
May 4		
May 11		
May 18		
May 25		

Do you have any respiratory illness / other concerns? YES / NO

Please list all other concerns

Are you currently suffering from any injuries? YES / NO

Please list previous injuries

Any new injuries since training stopped?

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Training Two Weeks Ago (Insert Date:)

	Hours	Intensity (Scale 0–10)	Cardio (Hours Total)	Top Three Activities
Upper Body				
Lower Body				
Middle Body				
Cardio				

Last Weeks Training (Insert Date:)

	Hours	Intensity (Scale 0–10)	Cardio (Hours Total)	Top Three Activities
Upper Body				
Lower Body				
Middle Body				
Cardio				

On a scale of 1–10, rate what you feel to be your current fitness level (compared to your last day in the gym).

1 2 3 4 5 6 7 8 9 10

List any concerns you may have about your return to training...

Provide some suggestions of how you feel your coach can support your return to full training...