PAR-Q and YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 to 69, the Par-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO.

YES	NO	
❑	❑	**1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
❑	❑	**2. Do you feel pain in your chest when you do physical activity?**
❑	❑	**3. In the past month, have you had chest pain when you are not doing physical activity?**
❑	❑	**4. Do you lose your balance because of dizziness or do you ever lose consciousness?**
❑	❑	**5. Do you have a bone or joint problem (for example, back, neck, knee, or hip) that could be made worse by a change in your physical activity?**
❑	❑	**6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
❑	❑	**7. Do you know <u>any other reason</u> why you should not do physical activity?**

if you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want—as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful to you.

NO to all questions

If you answered NO honestly to <u>all</u> PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- If you are not feeling well because of a temporary illness such as a cold or a fever – wait unit you feel better; **or**
- If you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell you fitness or health professional. Ask whether you should change your physical activity plan.

<u>Informed use of the PAR-Q:</u> The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completion of this questionnaire, consult your doctor prior to physical activity.

<u>NOTE:</u> If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

NOTE: This physical activity clearance is valid for a maximum of 12 months form the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

International Sports Sciences Association

Sotera Chelini

Screening Questionnaire

Please Fill Out All Information Below

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	

Please Check The Box For The Appropriate Answer

Has your doctor ever said you have heart trouble?	❒ Yes	❒ No
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? *(Note: This does not include the normal out of breath feeling that results from normal activity)*	❒ Yes	❒ No
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	❒ Yes	❒ No
Have you ever experienced rapid heart action or palpitations?	❒ Yes	❒ No
Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	❒ Yes	❒ No
Have you ever had rheumatic fever?	❒ Yes	❒ No
Do you have diabetes, hypertension, or high blood pressure?	❒ Yes	❒ No
Does anyone in your family have diabetes, hypertension, or high blood pressure?	❒ Yes	❒ No
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	❒ Yes	❒ No
Have you ever taken medications or been on a special diet to lower your cholesterol?	❒ Yes	❒ No
Have you ever taken digitalis, quinine, or any other drug for your heart?	❒ Yes	❒ No
Have you ever taken nitroglycerine or any other tablets for chest pain—tablets you take by placing under the tongue?	❒ Yes	❒ No
Are you overweight?	❒ Yes	❒ No
Are you under a lot of stress?	❒ Yes	❒ No
Do you drink excessively?	❒ Yes	❒ No
Do you smoke cigarettes?	❒ Yes	❒ No
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	❒ Yes	❒ No
Are you more than 65 years old?	❒ Yes	❒ No
Are you more than 35 years old?	❒ Yes	❒ No
Do you exercise fewer than three times per week?	❒ Yes	❒ No

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Sotera Chelini

Exercise History Questionnaire

Exercise History Information

Are you currently involved in a regular exercise program? ❒ Yes ❒ No

Do you regularly walk or run 1 or more miles continuously? ❒ Yes ❒ No

If yes, what is the average number of miles you cover in a workout? _____

What is your average time per mile? _____

Do you practice weightlifting or calisthenics? ❒ Yes ❒ No

Are you involved in an aerobic program? ❒ Yes ❒ No

If yes, what type(s)? _____

Do you frequently compete in competitive sports? ❒ Yes ❒ No

If yes which one(s)?

- ❒ Golf
- ❒ Bowling
- ❒ Tennis
- ❒ Handball
- ❒ Soccer
- ❒ Basketball
- ❒ Volleyball
- ❒ Football
- ❒ Baseball
- ❒ Track
- ❒ Other:_____
- ❒ Average number of times per week:_____

In which of the following high school or college athletics did you participate?

- ❒ None
- ❒ Football
- ❒ Basketball
- ❒ Baseball
- ❒ Soccer
- ❒ Other:_____
- ❒ Track
- ❒ Swimming
- ❒ Tennis
- ❒ Wrestling
- ❒ Golf

Do you frequently compete in competitive sports?

- ❒ Walking and/or Running
- ❒ Swimming
- ❒ Stationary Biking
- ❒ Jumping Rope
- ❒ Basketball
- ❒ Other:_____
- ❒ Bicycling (outdoors)
- ❒ Stationary Running
- ❒ Tennis
- ❒ Handball
- ❒ Squash

Comments:_____

_____

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NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS:_____
or GUARDIAN (for participants under the age of majority)

Sotera Chelini

Medical History Questionnaire

PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW

Member's Name:			Date:		
Please indicate in the space provided if you have a history of the following:					
1.	Heart attack		YES		NO
2.	Bypass or cardiac surgery		YES		NO
3.	Chest discomfort with exertion		YES		NO
4.	High blood pressure		YES		NO
5.	Rapid or runaway heartbeat		YES		NO
6.	Skipped heartbeat		YES		NO
7.	Rheumatic fever		YES		NO
8.	Phlebitis or embolism		YES		NO
9.	Shortness of breath w/ or wo/exercise		YES		NO
10.	Fainting or light-headedness		YES		NO
11.	Pulmonary disease or disorder		YES		NO
12.	High blood fat (lipid) level		YES		NO
13.	Stroke		YES		NO
14.	Recent hospitalization for any cause		YES		NO
	List specifics:				
15.	Orthopedic problems (including arthritis)		YES		NO
	List specifics:				

FOR ANY OF THE CONDITIONS CHECKED ABOVE, PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:

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Health History Questionnaire

Answer Each Question By Printing The Necessary Information. Your Answers Are Confidential.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

Medical Information

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:	❒ Yes	❒ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking: _____ _____ _____ _____	❒ Yes	❒ No
Please list any allergies:		
Has your doctor ever said your blood pressure was too high?	❒ Yes	❒ No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	❒ Yes	❒ No
Are you over the age of 65?	❒ Yes	❒ No
Are you unaccustomed to vigorous exercise?	❒ Yes	❒ No

Health History Questionnaire

Medical Information, continued

Is there any reason not mentioned why you should not follow a regular exercise program? ❒ Yes ❒ No
If yes, please explain:

Have you recently experienced any chest pain associated with either exercise or stress? ❒ Yes ❒ No
If yes, please explain:

Smoking

Please check the box that describes your current habits:

- ❒ Non-user or former user; Date quit:_____
- ❒ Cigar and/or pipe
- ❒ 15 or less cigarettes per day
- ❒ 16 to 25 cigarettes per day
- ❒ 26 to 35 cigarettes per day
- ❒ More than 35 cigarettes per day

Family and Personal Medical History

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- ❒ Asthma:_____
- ❒ Respiratory/Pulmonary Conditions:_____
- ❒ Diabetes: Type I:_____ Type II:_____ How Long?_____
- ❒ Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____
- ❒ Osteoporosis:_____

Lifestyle and Dietary Factors

Please fill in the information below:

- ❒ Occupational Stress Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Energy Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Caffeine Intake/Daily:_____ ❒ Alcohol Intake/Weekly:_____
- ❒ Colds Per Year:_____ ❒ Anemia:_____
- ❒ Gastrointestinal Disorder:_____
- ❒ Hypoglycemia:_____
- ❒ Thyroid Disorder:_____
- ❒ Pre/Postnatal:_____

Cardiovascular

Please fill in the information below:

- ❒ High Blood Pressure:_____ ❒ Hypertension:_____
- ❒ High Cholesterol:_____
- ❒ Hyperlipidemia:_____
- ❒ Heart Disease:_____
- ❒ Heart Disease:_____
- ❒ Heart Attack:_____ ❒ Stroke:_____
- ❒ Angina:_____ ❒ Gout:_____

Health History Questionnaire

Family and Personal Medical History, continued

Musculoskeletal Information

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- ❒ Head/Neck:_____
- ❒ Upper Back:_____
- ❒ Shoulder/Clavicle:_____
- ❒ Arm/Elbow:_____
- ❒ Wrist/Hand:_____
- ❒ Lower Back:_____
- ❒ Hip/Pelvis:_____
- ❒ Thigh/Knee:_____
- ❒ Arthritis:_____
- ❒ Hernia:_____
- ❒ Surgeries:_____
- ❒ Other:_____

Nutritional Information

Are you on any specific food/diet plan at this time? If yes, please list:	❒ Yes	❒ No
Do you take dietary supplements? If yes, please list:	❒ Yes	❒ No
Do you experience any frequent weight fluctuations?	❒ Yes	❒ No
Have you experienced a recent weight gain or loss? If yes, list change: Over how long?	❒ Yes	❒ No
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*		

Health History Questionnaire

Work And Exercise Habits

Please check the box that best describes your work and exercise Habits.

- ❒ Intense occupational and recreational exertion
- ❒ Moderate occupational and recreational exertion
- ❒ Sedentary occupational and intense recreational exertion
- ❒ Sedentary occupational and moderate recreational exertion
- ❒ Sedentary occupational and light recreational exertion
- ❒ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Home: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Do you work more than 40 hours a week? ❒ Yes ❒ No

Please make any other comments you feel are pertinent to your exercise program.

_____

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NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Sotera Chelini

Confidentiality Agreement

PLEASE READ THE BELOW STATEMENT AND SIGN WHERE INDICATED.

I, _____ understand that the information collected by **Sotera Chelini** _____ will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
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Sotera Chelini

Informed Consent

PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW

I, (print name) _____, give my consent to participate in the physical fitness evaluation program conducted by **Sotera Chelini**.

BENEFITS

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

RISKS

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

TESTING AND EVALUATION RESULTS

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or bicycle ergometer test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide **Sotera Chelini** with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at **Sotera Chelini**, and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
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