Physical Activity Readiness Questionnaire (PAR-Q)

Name		**Date**	

Address			
City		**Zip Code**	
Telephone (Day)		**Telephone (Evening)**	

Gender	
Email	

Date of Birth		**Age**	
Emergency Contact		**Relationship**	
Emergency Contact Phone			

GENERAL HEALTH

- Regular exercise is associated with many health benefits, yet any change of activity may increase the risk of injury.
- Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life.
- Please read each question carefully and answer every question honestly:

☐ Y ☐ N 1. Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?

☐ Y ☐ N 2. When you do physical activity, do you feel pain in your chest?

☐ Y ☐ N 3. When you were not doing physical activity, have you had chest pain in the past month?

☐ Y ☐ N 4. Do you ever lose consciousness or do you lose your balance because of dizziness?

☐ Y ☐ N 5. Do you have a joint or bone problem that may be made worse by a change in your physical activity?

☐ Y ☐ N 6. Is a physician currently prescribing medications for your blood pressure or heart condition?

☐ Y ☐ N 7. Are you pregnant or post-partum?

☐ Y ☐ N 8. Do you have insulin dependent diabetes?

☐ Y ☐ N 9. Are you a man over the age of 45 or a woman over the age of 55?

☐ Y ☐ N 10. Do you know of any other reason you should not exercise or increase your physical activity?

If you answered...

YES to one or more questions: It is strongly recommended that you have a Medical Examination completed BEFORE you become significantly more physically active.

NO to all questions: If you answered NO honestly to all questions you can be reasonably sure that you can become more physically active and take part in a fitness training program.

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

Height		**Weight**		**Gender**		**Age**	

Body Fat		**BMI**	

What are your fitness goals in general?

Rate the following on a scale of 1-10? (10 being the highest level)

Fitness level	
Energy level throughout the day	
Current stress level	

What is your occupation?

How many hours of sleep do you get per night?

Please check any of the following activities that you have participated in the past:

☐ aerobic training ☐ strength/resistance training/Pilates

☐ high intensity training ☐ flexibility training/Yoga

☐ sports ☐ mind/body exercise

☐ personal training

Which activities did you find successful and why?

On a scale of 1-10 how committed are you to reaching your current fitness goals?

Daily Habits

How many meals do you eat per day?	
Do you eat:	☐ Breakfast ☐ Lunch ☐ Dinner
How many glasses of water do you drink per day?	
How many drinks containing caffeine do you drink per day?	
Do you eat sugar?	
Do you drink alcohol?	
Do you smoke?	

Do you feel you are at your ideal weight?

List any medications that you are currently taking:

List any allergies you have:

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

Participant's Signature		**Date**	
Signature of Parent/Guardian		**Date**	