

# PAR-Q FORM



*Please complete this form as accurately and completely as possible.*

**Please mark YES or No to the following:**

	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have pains in your chest when you perform physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had chest pain when you were not doing physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose your balance due to dizziness or do you ever lose consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e., diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant now or have given birth within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma or exercise induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have low blood sugar levels (hypoglycemia)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a recent surgery?	<input type="checkbox"/>	<input type="checkbox"/>

If you have marked YES to any of the above, please elaborate below:

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Do you take any medications, either prescription or non-prescription, on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
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What is the medication for? \_\_\_\_\_

How does this medication affect your ability to exercise or achieve your fitness goals?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note: If your health changes such that you could then answer YES to any of the above questions, tell your trainer/coach. Ask whether you should change your physical activity plan.

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

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_