Physical Activity Readiness Questionnaire (Par-Q)
Health History Questionnaire

Name: _____ Age: _____ Date: _____ D.O.B._____
Address: _____
Home Phone #: _____ Cell: _____
E-mail Address: _____
Emergency Contact: Name_____ Phone _____
Relationship_____
Occupation: _____
Personal Physician: _____ Phone _____

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 and 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.

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 were 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, 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 of any other reason why you should not do physical activity?

HEALTH HISTORY
Please indicate your history related to each of the following conditions by checking the appropriate box. If you have had any condition in the past, please indicate the date in the appropriate space.

	Yes	No		Yes	No
Heart Condition			Dizziness		
Stroke			Pregnant		
Diabetes			Thyroid		
Arthritis			Asthma		
Anemia			Varicose Veins		
High Blood Pressure			Cancer		
High Cholesterol			Osteoporosis		
Chest Pain/discomfort			Shortness of Breath		

ORTHOPEDIC PROBLEMS
Do you suffer from any of the following? (circle all that apply)

Back pain Neck pain
Shoulder pain Knee pain
Ankle pain Abdominal Pain
Hip/Pelvis pain Other

Have you had any injuries? If YES, please list and explain.
_____

Have you had any surgeries? If YES, please list and explain.
_____

Any other medical problems/concerns not already identified? Yes No please list below
_____
_____

Are you taking any prescription medication? Yes No If yes list below.
Medication Reason for Taking For how long?
_____
_____

I have read, understand and completed this questionnaire. I certify that the above information is true and correct. I understand that a Doctor's note may be requested upon evaluation of this information. If a note is required, I should not proceed with an exercise until physician clearance has been received.

Name: _____ *Date:* _____

Signature: _____