

PAR-Q (Physical Activity Readiness Questionnaire)

Today's Date: _____

For most people, physical activity should not pose any problem or hazard. This questionnaire has been designed to identify those people for whom physical activity might be inappropriate, or those who should have medical advice concerning the type of activity most suitable for them. If you answer "yes" to any of the questions below, consult with your doctor before starting any exercise program.

Name _____ Sex: ___M ___F

Mailing Address _____

City _____ State _____ Zip Code _____ - _____

Home Phone (_____) _____ Business Phone (_____) _____

E-mail Address _____

Birthdate _____ Age _____

Employer's Name _____

Height _____ ft _____ in Weight _____ lbs. Date of Last Physical Exam _____

Personal Physician _____ Phone _____

Goals: _____

Limitations: _____

How many days per week can you commit to a resistance program? _____

How many days per week can you commit to a cardiovascular program? _____

What is the total amount of time per day you can commit to an exercise program? _____

How can we best assist you with a nutrition program? _____

How did you hear of Tools for Life® and Iron Athlete, Inc.®? _____

General History

YES / NO

Do you currently have an illness or infection? Please specify: _____

Has your physician ever told you that:

your cholesterol was too high?

your triglycerides were too high?

Do you have history of high blood pressure?

Have you been diagnosed with diabetes?

If yes: Are you taking medication?

_____Oral _____Injection

What kind of diabetes? _____Type I _____Type II

General History, cont.

YES / NO

Do you have a history of the following conditions?

- Allergies
- Infectious mononucleosis
- Anemia
- Multiple sclerosis
- Epilepsy or other seizures
- Liver disorder
- Gallbladder problems
- HIV positive
- Renal disorder
- Thyroid disorder
- Other: Specify _____

Family History(Immediate family only)	No	Yes	If yes:Age >50	If yes: Age <50
Heart Attacks				
High Blood Pressure				
High Cholesterol				
Stroke				
Angina (Chest Pain)				
Diabetes				
Congenital Heart Disease				
Aneurysms				
Heart Operations				
Asthma/Hay Fever				
Obesity				
Osteoporosis				
Cancer				

Smoking History

YES / NO

Do you currently smoke?

If so, for how many years? _____

Number of cigarettes, cigars and/or pipe bowls (circle one) smoked per day? _____

If you are an ex-smoker, when did you stop? _____

Pulmonary History

YES / NO

Do you experience breathlessness after mild exercise?

Have you ever experienced any of the following:

Asthma? When _____

Bronchitis? When _____

Emphysema? When _____

Pneumonia? When _____

Lung Disease? When _____

Other? Specify _____

Medications

YES / NO

Are you currently taking any medications?

If yes, please list:

<u>Medication</u>	<u>Condition</u>
<u>Over the Counter Supplements</u>	<u>Condition</u>

Nutritional History

Average number of caffeine drinks per day _____

Average number of alcoholic drinks per day _____

Are you presently dieting? _____yes _____no

If yes, what kind of diet? _____

Have you participated in structured diet plans in the past? _____yes _____no

If yes, please list:

Name of Diet	Dates	Weight Lost	How Long Maintained Weight Loss?

Cardiovascular History

YES / NO

Have you ever had any of the following:

- Heart attack or stroke
- Cardiac or vascular surgery or congestive heart failure
- Cardiomyopathy (heart enlargement)
- Abnormal resting or exercise EKG
- Coronary artery disease
- Rheumatic fever
- Phlebitis

Do you have a history of any of the following:

- Angina (chest pain)
- Palpitations or tachycardia
- Badly swollen feet or ankles
- Severe dizziness or fainting
- Heart murmur
- Claudication (pain in the legs)

Lifestyle

Is your occupation:

- _____ Sedentary
- _____ Moderately active
- _____ Active
- _____ Heavy labor

How stressful is your occupation?

- _____ Minimal
- _____ Moderate
- _____ Average
- _____ Extreme

How would you characterize your overall stress level? _____ high _____ medium _____ low

Average number of hours you sleep per night? _____

Emergency contact:

Phone:

Relationship:

I understand the nature and purpose of the Physical Activity Readiness Questionnaire and am aware that any strenuous physical activity involves risks. Accordingly, I release, discharge, absolve, and hold harmless Tools for Life, their agents, instructors and employees, for any and all liability arising from any accident, injury, or loss sustained by me as a result of activities at or present in the Facility. I declare to the best of my knowledge my answers are true, correct, and complete.

Signature

Guardian Signature (if under 18 years of age)

Date

Reviewed by