

Physical Activity Readiness Questionnaire (PAR-Q)

Health and Lifestyle screening questionnaire.

Certain injuries and illnesses may prevent individuals from participating in physical activity, in such cases a doctors note maybe required. All details will be kept for the duration of your training, for 6 months after, and subsequently destroyed.



Your Personal Details:

Name: _____ D.O.B: _____

Address: _____ Postcode: _____

Email: _____

Phone: _____

Your Emergency Contact:

Name: _____ Relation: _____

Address: _____ Postcode: _____

Email: _____

Phone: _____

Medical History (please circle)

Have you had any major illness in the last 5 years ? YES / NO

If 'yes' please expand: _____

Are you receiving treatment for a diagnosed condition ? YES / NO

If 'yes' please expand: _____

Are you taking any prescription medication ? YES / NO

If 'yes' please expand: _____

Please indicate if you've ever suffered from any of the following :

Unusually short of breath with very light exercise? YES / NO

Pain, Pressure, Heaviness or Tightness in the chest area? YES / NO

Regularly experience unexplained pain in abdomen, shoulder or arm? YES / NO

Sever dizzy spells or fainting? YES / NO

Regularly get lower leg pain which is relived by rest? YES / NO

Ever experience palpitations or irregular heartbeats? YES / NO

Are you currently pregnant? YES / NO

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Health, Nutrition & Fitness Goals

Short and Long Term Goals



What are your main reasons for starting a fitness programme?

- | | | | | | |
|----------------------|--------------------------|-------------------|--------------------------|-------------|--------------------------|
| General Conditioning | <input type="checkbox"/> | Muscular Strength | <input type="checkbox"/> | Appearance | <input type="checkbox"/> |
| Weight / Fat Loss | <input type="checkbox"/> | Aerobic Fitness | <input type="checkbox"/> | Self Esteem | <input type="checkbox"/> |
| Stress Management | <input type="checkbox"/> | Other... | <input type="checkbox"/> | | |

2 x Short Term Physical Goals (in the next 3 months) and 1 Long Term Goal:

1.

2.

Long Term:

2 x Short Term Nutrition Goals and 1 Long Term Goal:

1.

2.

Long Term:

What are you looking forward to from achieving your goals?

-

-

-

Nutrition, Diet and Lifestyle

On a scale of 1 to 10 (10 being the best) how would you rate your eating habits? _____

Do you follow any specific diet or structured eating? _____

Allergies and intolerances? _____

Do you smoke? And how much? _____

Do you drink alcohol? And how much? _____

Would you like assistance changing any of these habits? _____

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Structural Pain and Client Declaration



Using the figure below, please indicate any pain or injuries:

Have any of these pains been investigated or diagnosed? YES / NO

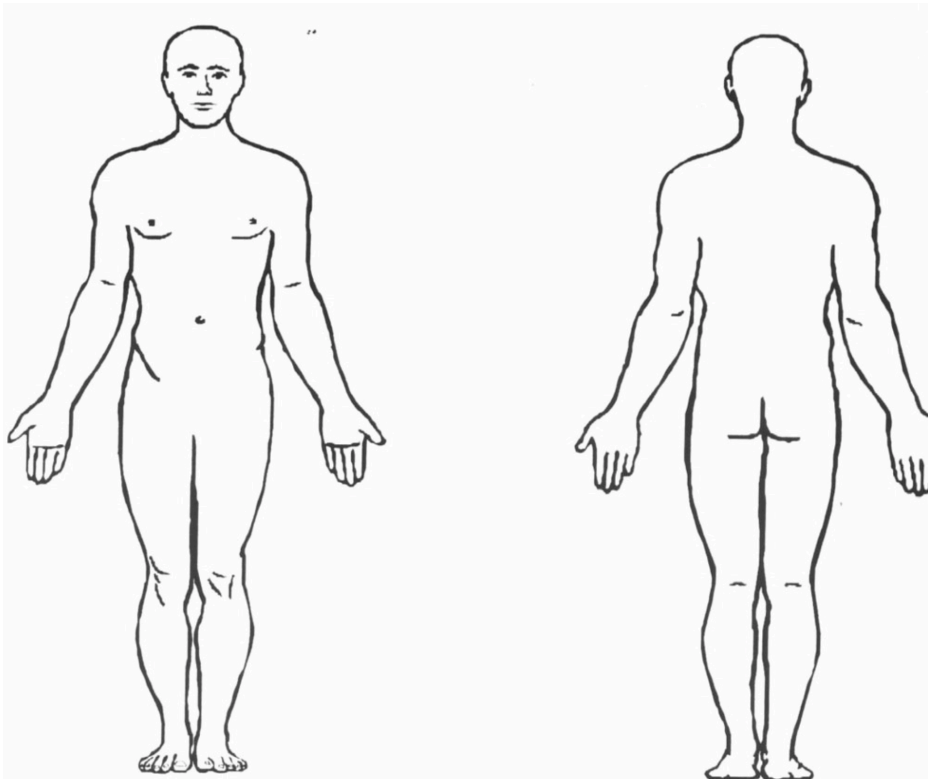
If 'yes' please expand _____

Are any of these injuries aggravated by exercise? YES / NO

If 'yes' please expand _____

Are you receiving treatment for any structural problem? YES / NO

If 'yes' please expand _____



Please indicate any other health issues not previously mentioned _____

Have you ever been told not to exercise by a medial professional ? YES / NO

Client declaration

Please bear in mind, it is your responsibility to inform me if any of your circumstances change.

I can confirm I have answered honestly and that the information given is correct.

Print Name:

Date:

Signature: