

Physical Activity Readiness Questionnaire (PAR Q)

Your Personal Details

Client Name:

Date Of Birth:

Main Focus:

Email Address:

Contact Number:

Emergency Contact Details

Name:

Email Address:

Contact Number:

Your Health Goals

What health goals would you like to achieve in the next 3 months?

What are your main reasons for starting a fitness programme?

- General conditioning
- Flexibility
- Weight / fat loss
- Appearance
- Stress Management
- Improve Self-Esteem
- Muscular Strength
- Others
- Aerobic Fitness

How would you describe your general health and fitness?

Have you done any structured exercise?

Yes

No

If 'Yes', what did you do?

buskdaley.com

What type of exercise do you enjoy the most?

What type of exercise do you dislike the most?

What would you say are the main barriers preventing you from exercising?

- Lack of facilities
- Family
- Injury / Illness
- No time
- Lack of knowledge
- Appearance
- No motivation
- Work
- Unfit
- Others: _____

Diet and Nutrition

On a scale of 1 – 10 (with 1 being poor and 10 being excellent) how would you assess the quality of your eating habits?

Would you like any help or advice in changing the quality of your eating habits?

Yes

No

Do you follow any particular diet or eating patterns?

Lifestyle

Do you drink alcohol?

Yes – how much?

No

Do you smoke?

Yes – how much?

No

Personal Reward:

buskdaley.com

Physical AcMedical History

Have you had a major illness or injury in the last 5 years?

Yes

No

Main Focus:

If 'Yes' please give details:

Are you receiving treatment for any diagnosed medical condition?

Yes

No

If 'Yes' please give details:

Are you taking any prescription medication?

Yes

No

If 'Yes' please give details:

Please indicate if you ever experience any of the following symptoms. Do you:

Ever get unusually short of breath with very light exertion?

Yes

No

If 'Yes' please give details:

Ever have pain, pressure, heaviness, or tightness in the chest area?

Yes

No

If 'Yes' please give details:

Regularly have unexplained pain in the abdomen, shoulders, or arm?

Yes

No

If 'Yes' please give details:

Personal Health Information

Physical Health Information

Medical History

Medication

Diagnosis

Treatment

Test Results

Prescription

Refill

Notes

Comments

Signatures

Printed Name

Date

Signature

Printed Name

Ever have severe dizzy spells or episodes of fainting?

Yes

No

If 'Yes' please give details:

Main Focus

Regularly get lower leg pain during walking that is relieved by rest?

Yes

No

If 'Yes' please give details:

Ever experience palpitations or irregular heartbeats?

Yes

No

If 'Yes' please give details:

Are you currently pregnant or have given birth in the last 6 months?

Yes

No

Structured Health

Please indicate on the figures below any aches, pains, or problem areas.

Please give details of any areas indicated:

Are any of these injuries aggravated by exercise?

Yes

No

Are you currently receiving treatment for any structural problem?

Yes

No

Please indicate any other health problems you suffer, from which you have not already mentioned:

Participant Declaration

I, the undersigned, have read, understood to my full satisfaction, and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that my Personal Trainer may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name:

Date:

Signature:

Witness:

Signature of Parent / Guardian / Care Provider: