

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? _____

Do you frequently have pains in your chest when you perform physical activity? _____

Have you had chest pain when you were not doing physical activity? _____

Do you lose your balance due to dizziness or do you ever lose consciousness? _____

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.)? _____

Are you pregnant now or have you given birth within the last 6 months? _____

Have you had a recent surgery? _____

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

Do you have any chronic illness or physical limitations such as Asthma, diabetes? Yes/No

Do you have any injuries or orthopedic problems such as bursitis, bad knees, back, shoulder, wrist or neck

issues? YES/ NO Please specify _____

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

What is the medication for? _____

How does this medication affect your ability to exercise or achieve your fitness goals? Yes/No

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how many? _____

2) Do you drink alcohol? YES NO If yes, how many units per week? _____

3) How many hours do you regularly sleep at night? _____

4) Describe your job: Sedentary Active Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

7) List your 3 biggest sources of stress:

a. _____ b. _____ c. _____

8) Is anyone in your family overweight? Mother Father Sibling Grandparent

9) Were you overweight as a child? YES NO If yes, at what age(s)?

T-FIT INC LTD
PAR-Q FORM

Name: _____ **Date of Birth:** / / .
Address: _____
:

Signed: _____ Date:

Signed: _____ Date:

Parent/ Guardian countersign(if client is under 16 years old)