HEALTH SCREENING FORM- PAR-Q
PHYSICAL ACTIVITIES READINESS QUESTIONNAIRE

Common sense is your best guide in answering these few questions. Please circle the appropriate answer, **YES or NO**.

YES NO	1. Has your doctor ever told you that you have a heart or lung problem?
YES NO	2. Have you ever had any heart related problems?
YES NO	3. Do you frequently feel any chest discomfort or pain?
YES NO	4. Do you often feel faint or have spells of severe dizziness?
YES NO	5. Has your doctor ever told you that you have high blood pressure, or have you ever had high blood pressure in the past, or are you presently taking any medications for blood pressure?
YES NO	6. Are you aware of any bone, back or joint problems that may be, or could be aggravated by exercise? (Arthritis, surgery)
YES NO	7. Have you ever had an episode of exercise induced asthma, that is, severe wheezing, coughing or severe shortness of breath brought on by exercise, or shortness of breath at rest or with mild exertion?
YES NO	8. Do you ever have episodes of labored or difficult breathing during the night?
YES NO	9. Have you ever been told by your doctor that you have diabetes?
YES NO	10. Are you over the age of 65 and not involved in any regular exercise?
YES NO	11. Is there a good reason not mentioned here why you should not engage in exercise or rehabilitation even if you wanted to?
YES NO	12. Are you pregnant?

Comments: _____

_____

I certify that the above information is correct.

_____ **Date:**_____

Patient Signature

☐ The above "YES" checked boxes were discussed with the patient and it has been deemed that the patient is currently under care of a medical physician and any conditions are thereby controlled or deferred to the MD's treatment. This patient may proceed with active rehab.

OTHER REASON:_____

_____

PHYSICIAN SIGNATURE:_____

☐ The above "YES" checked boxes were discussed with the patient and they many not engage in any fitness test or exercise program until a medical clearance form is completed and signed by a Medical Physician.

MEDICAL CLEARANCE FORM

☐ I hereby certify that, to the best of my knowledge, this person examined has no contraindications to participate in a guided rehabilitation or fitness program.

☐ I recommend the following limitations/precautions:

_____

_____

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN PHONE NUMBER: (_____) _____ - _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____