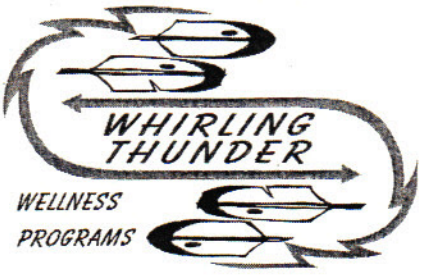

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

The PAR-Q is a simple screening tool used to identify individuals who should not be tested in a field setting without physician clearance. The PAR-Q is used throughout North America.

Yes	No	
___	___	1. Has you doctor ever said that you have a heart condition and recommended only medically approved physical activity?
___	___	2. Do you have chest pain brought on by physical activity?
___	___	3. Have you developed chest pain at rest in the past month?
___	___	4. Do you lose consciousness or lose your balance as a result of dizziness?
___	___	5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?
___	___	6. Is your doctor currently prescribing medication for your blood pressure or heart condition (e.g., diuretics or water pills)?
___	___	7. Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?

Note: 1) This questionnaire applies only to those 15 to 69 years of age.

2) If you have a temporary illness, such as a fever, or are not feeling well at this time, you may wish to postpone the proposed activity.

3) If you are pregnant, you are advised to consult with your physician before exercising.

4) If there are any changes in your status relative to the above questions, please bring this information to the immediate attention of your fitness professional.

Which best describes your level of physical activity during the past 4-6 weeks?

___ Very active

___ Moderately active

___ Occasionally active

___ Inactive

Please list below any additional *exercise* information which you think is important for us to know prior to fitness training.

Is there a family history of heart disease, hypertension, stroke, diabetes, heart failure, lung disease or epilepsy? ___ Yes ___ No

If "Yes", please provide information regarding relationship, medical problem and age at onset or death.

___ Yes ___ No Do you currently smoke cigarettes?
If "Yes", how many per day? ____
If you smoked in the past, when did you quit? ____

___ Yes ___ No Are you currently taking medication prescribed by a physician? If "Yes", indicate name of medication, dosage and reason why you are taking it.

Please indicate below any additional *medical* information that you think is important for us to know prior to fitness training.