Physical Activity Readiness Questionnaire (PAR Q)

Your Personal Details

Client Name: _____ Date Of Birth: _____

Email Address: _____ Contact Number: _____

Emergency Contact Details

Name: _____

Email Address: _____ Contact Number: _____

Your Health Goals

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

_____

_____

_____

What are your mail reasons for starting a fitness programme?

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

_____

How would you describe your general health and fitness?

_____

_____

_____

Physical Activity Readiness Questionnaire (PAR Q)

Have you done any structured exercise? ☐ Yes ☐ No

If 'Yes' what did you do? _____

_____

_____

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
☐ Injury / Illness
☐ Lack of knowledge
☐ No motivation
☐ Unfit
☐ Family
☐ No time
☐ Appearance
☐ Work
☐ 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

Physical Activity Readiness Questionnaire (PAR Q)

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*

Medical History

Have you had a major illness or injury in the last 5 years? ☐ Yes ☐ No

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:

(1) Ever get unusually short of breath with very light exertion? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

Physical Activity Readiness Questionnaire (PAR Q)

(2) Ever have pain, pressure, heaviness, or tightness in the chest area? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

(3) Regularly have unexplained pain in the abdomen, shoulders, or arm? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

(4) Ever have severe dizzy spells or episodes of fainting? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

(5) Regularly get lower leg pain during walking that is relieved by rest? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

(6) Ever experience palpitations or irregular heartbeats? ☐ Yes ☐ No

If 'Yes' please give details - _____

_____

_____

(7) Are you currently pregnant or have given birth in the last 6 months? ☐ Yes ☐ No

Physical Activity Readiness Questionnaire (PAR Q)

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.

_____

_____

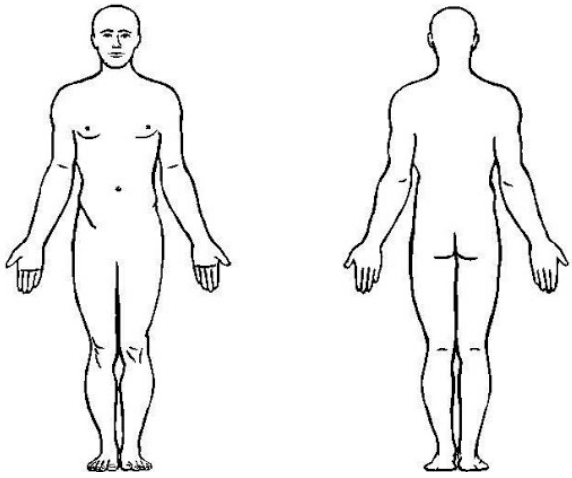
_____

_____

_____

_____

_____



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: _____