Physical Activity Readiness Questionnaire

This form is to be completed in preparation for physical activity. It is important you disclose all of your existing medical conditions so that the personal trainer may determine whether to see further medical advice before commencing an exercise program. This questionnaire does not provide medical advice in any form and does not substitute advice from an appropriately qualified professional.

CHAMPIONS
RECOVERY ROOM

Full Name_____

Email Address _____

Address _____ **City** _____

Personal Phone _____ **Work Phone** _____

Emergency Contact _____ **Relation to** _____

Personal Phone _____ **Work Phone** _____

Primary Physician _____ **Work Phone** _____

Section 1

General Health:	**Yes**	**No**
1. Has your doctor ever said that you have a heart condition?		
2. Has your doctor ever said that you have high blood pressure?		
3. Do you feel pain in your chest at rest, during you daily activities, or when you do physical activity?		
4. Do you lost balance because of dizziness or have you lost consciousness in the last 12 months?		
5. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?		
6. Are you currently prescribed medications for a chronic medical condition?		
7. Do you have a bone or joint problem that could be made worse by becoming physically active? Please answer NO if you have a joint/bone		

problem in the past that no longer limits your physical activity abilities.		
8. Has your doctor ever said that you should only do medically supervised physical activity?		

If you answered NO to all the questions above, you are cleared for physical activity. Please skip section 2, and move to section 3 of the form.

If you answered YES to one or more questions, PLEASE CONTINUE TO SECTION 2.

Section 2

Chronic Medical Conditions:	**Yes**	**No**
1. Do you have arthritis, osteoporosis, or back problem?		
2. Do you have cancer of any kind?		
3. Do you have heart disease or cardiovascular disease? (Coronary artery disease, high blood pressure, heart failure, diagnosed abnormal heart rhythm)		
4. Do you have any metabolic conditions? (Pre-diabetes, type I or type II)		
5. Do you have any mental health difficulties (Alzheimers, dementia, depression, anxiety disorder, eating disorder, or other)		
6. Do you have respiratory disease?		
7. Do you have Hepatics B, Hepatitis C, HIV/Aids or any other blood related health conditions?		
8. Have you had a stroke?		
9. Do you have any other medical conditions not listed above?		

If yes to question 8 please explain below

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Section 3

Disclaimer: If you have answered no to all of the above questions and you are confident that you have no other concerns with your health then you may proceed to participate in physical activity. If you have answered yes to any of the questions above or are unsure, please seek referral from your physician or allied health professional before starting physical activity.

I believe to the best of my knowledge that all the information I have provided on this form is accurate. In the case that my medical condition changes over the course of my training, I will inform my trainer and fill out a new health history screening questionnaire.

Client Signature _____ Date _____

Employee Signature _____ Date _____