



Centers for
Orthopaedics
Experience in Motion

Physical Activity Readiness Questionnaire (PAR-Q)

Name: _____

Date: _____

A Questionnaire for People Ages 18 to 69

Regular physical activity is fun and healthy, and more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 18 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1.) Has your doctor ever said that you have a heart condition <i>and</i> that you should only do physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2.) Do you feel pain in your chest when do physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3.) In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4.) Do you lose your balance because of dizziness, or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5.) Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by change in your physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6.) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7.) Do you know of any other reason why you should not do physical activity? |

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and to which questions you answered YES.

You may be able to do any activity you want—as long as you start slowly and building up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

Find out which community programs are safe and helpful for you.

If you answered NO to all of the questions

If you answered NO honestly to *all* PAR-Q questions, you can be reasonably sure that you can:

Start becoming much more physically active—begin slowly and build up gradually. This is the safest and easiest way to go.

Take part in a fitness appraisal—this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

PLEASE NOTE:

If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

DELAY BECOMING MUCH MORE ACTIVE:

If you are not feeling well because of temporary illness such as a cold or fever—wait until you feel better or;

If you are or may be pregnant—talk to your doctor before you start becoming more active.



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Medical History and Present Medical Condition Questionnaire

Name: _____

Date: _____

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

PERSONAL MEDICAL HISTORY

YES NO

- Allergies
- Loss of hearing
- Asthma
- Kidney disease
- Prostatitis
- Colitis
- Hepatitis
- Liver Disease
- Elevated liver enzyme test
- Pancreatitis

YES NO

- Ulcer
- Heart attack
- Heart murmur
- Positive stress test
- Heart valve abnormality
- Angina
- Heart failure
- High Cholesterol
- High blood pressure
- Arthritis/rheumatism
- Loss of consciousness

YES NO

- Epilepsy
- Convulsions/seizures
- Stroke
- Diabetes
- Thyroid trouble
- Anemia
- Eczema
- Cancer
- Sleep apnea

REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following

:

Eyes, Ears, Nose, Throat

YES NO

- Difficulty with night vision
- Change in vision
- Blurred or double vision
- Bleeding gums
- Frequent nosebleeds
- Frequent sinus trouble
- Recent hoarseness
- Ringing/buzzing ears
- Earaches

Pulmonary

YES NO

- Shortness of breath
- Chronic or frequent cough
- Brown/blood-tinged sputum
- Chest tightness
- Wheezing

Genito-Urinary

YES NO

- Bladder trouble
- Blood in urine
- Irregular vaginal bleeding
- Currently pregnant
- Difficulty starting/stopping urination
- Urinating 3 times per night
- Frequent or painful urination
- Problems with sexual function

Gastrointestinal

YES NO

- Vomited blood
- Persistent diarrhea
- Persistent constipation
- Frequent abdominal pain
- Frequent nausea
- Frequent indigestion/heartburn
- Black/bloody bowel movement
- Hemorrhoids
- Trouble swallowing
- Hernia

Central Nervous System

YES NO

- Fainting spells
- Recurrent dizziness
- Frequent headaches
- Tremors
- Memory Loss
- Loss of coordination
- Difficulty concentrating
- Numbness/tingling extremities

Heart/Vascular

YES NO

- Palpitation (irregular heartbeat)
- Pain or discomfort in chest
- High Cholesterol
- Swelling of feet
- Leg pain while walking
- Painful varicose veins

Musculoskeletal

Miscellaneous

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/> Back trouble/pain	<input type="checkbox"/>	<input type="checkbox"/> Bleeding/bruising easily	<input type="checkbox"/>	<input type="checkbox"/> Night sweats
<input type="checkbox"/>	<input type="checkbox"/> Neck trouble/pain	<input type="checkbox"/>	<input type="checkbox"/> Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/> Undesired weight loss
<input type="checkbox"/>	<input type="checkbox"/> Joint injury/pain/swelling	<input type="checkbox"/>	<input type="checkbox"/> Rashes	<input type="checkbox"/>	<input type="checkbox"/> Snoring
<input type="checkbox"/>	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/> Unexplained lumps	<input type="checkbox"/>	<input type="checkbox"/> Difficulty sleeping
		<input type="checkbox"/>	<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/> Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES NO

- Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
- Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage and the reason the medication is used on the next page.
- Have you had any surgical operations in the last 10 years?
- Has anyone in your immediate family developed heart disease before the age of 60?
- Do any diseases run in your family?
- Do you currently have a cold/cough, or have you had any in the last two weeks?
- Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.
- Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.
- Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
- Do you have any special concerns regarding your health that you would like to discuss with the doctor?
- Are you a current cigarette smoker?
 - a.) How many packs of cigarettes do you smoke a day? _____
 - b.) How long have you been smoking? _____
- Are you an ex-smoker?
 - a.) How many years did you smoke? _____
 - b.) How many packs a day? _____
 - c.) When did you quit? _____
- Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

When were your most recent immunizations?

Tetanus _____ Flu Shot _____ Pneumovax _____

When were your most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

My current diet could be best characterized as (check all that apply):

- Low-Fat
- Low-Carb
- High-Protein
- Vegetarian/Vegan
- No Special Diet



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Comprehensive Client Information Sheet

Name: _____ Date: _____

INSTRUCTIONS

This is your comprehensive client information sheet, in which we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. Please answer all questions in the most accurate manner possible while being as concise as possible.

DISCLAIMER:

Please recognize the fact that it is your responsibility to work directly with your physician before, during and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

COMPREHENSIVE CLIENT INFORMATION SHEET

PART I: BASIC INFORMATION

Name: _____ Gender: _____ Age: _____

Date of birth (month/day/year): ____ / ____ / ____ Height: _____ Weight: _____

Body fat percentage (have this taken before submitting this sheet) _____

PART II: GOALS

Given the following goals, please rank them in order of importance, with 1 being the **most important** and 8 being the **least important**.

Improved health _____ Improved endurance _____ Increase strength _____ Sport-specific* _____

Increased muscle mass _____ Fat Loss _____ Increased Power _____ Weight gain _____

* Please provide the sport or athletic event for which you are training:

COMPREHENSIVE CLIENT INFORMATION SHEET

Do you have a specific timeline for achieving a specific goal? If so, please specify.

Circle which type of progress is more important to you:

Immediate progress that's less easily maintained

Maintainable progress that may not be as rapid

Please explain below:

EXERCISE INFORMATION:

Rate your ability in the following exercises (check the box that corresponds with your ability):

EXERCISES:	ADVANCED	INTERMEDIATE	NOVICE	UNFAMILIAR
Barbell Squats				
Barbell deadlift				
Barbell bench press				
Bent-over barbell row				
Barbell shoulder press				
Pull-up				

Are you currently exercising regularly (at least 3x per week)?

Yes No

If you answered **YES**, continue on to the following section.

If you answered **NO**, skip ahead to the section marked "**Not currently exercising**".

Complete this section if you ARE currently exercising regularly

How long have you been consistently exercising without a break?

On the following chart, fill in which type of exercise you normally perform each day, resistance training (RT), interval cardio bouts (INT); low-intensity cardio bouts (LIC); sport-specific work (SSW).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Type of Exercise							



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COMPREHENSIVE CLIENT INFORMATION SHEET

On the following chart, fill in your approximate workout duration for each day (in minutes).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Duration							

Please submit your current exercise regimen along with this form (type it up or write it out for us).

Complete this section if you ARE NOT currently exercising regularly.

If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)?

Yes No

If you have exercised on a consistent basis previously, how long ago was this and how long did it last?

MEDICAL AND HEALTH INFORMATION

What additional therapies or interventions are being undertaken for the given health problem(s)?

If you have any injuries, please list them. _____

What additional therapies or interventions are being undertaken for the given injury(s)?

LIFESTYLE INFORMATION

What do you do for a living? _____

What is the activity level at your job?

None (seated work only) Moderate (light activity such as walking) High (heavy labor, very active)

Does your job involve shift work?

Yes No

If you follow a more regular schedule, do you work days, afternoons or nights? _____

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

Yes No

How often do you travel?

Rarely A few times a year A few times a month Weekly

Please list the physical activities that you participate in outside of the gym and outside of work.

COMPREHENSIVE CLIENT INFORMATION SHEET

Exactly how much money do you spend on groceries per month (provide amounts from your last two grocery bills)?

How many times per week do you shop for groceries? _____

How many meals do you eat in restaurants and/or fast food places per week? _____

Exactly how much money do you spend on supplements per months? _____

If you have any known food allergies, please list them below.

Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

If you are currently using any nutritional supplements, please list them (as well as the doses you are taking) below.

MISECELLANEOUS INFORMATION

If there is any other information you think might be relevant to your program design, please share it with us below.

Please share your most frequent health, nutrition, or physique complaints and/or dissatisfactions with us.

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable) and three-day diet record to your first appointment.



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Readiness for Change Questionnaire

Name: _____ Date: _____

One of the most important things you can do to change your lifestyle for the better is understand your readiness for change. In other words, although you might *want* to be in great shape, there is a difference between wanting it and being ready to do the work necessary to accomplish it. In this questionnaire we'll find out if you're really ready to make the changes necessary to improve your body composition, health and physical performance.

Simply answer the questions below by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find out if you're really ready to make a lifestyle change. So don't lie to yourself.

READINESS FOR CHANGE QUESTIONNAIRE

QUESTIONS:

- 1.) Do you look in the mirror and feel frustrated, upset or humiliated because of how your body looks?
- 2.) When you feel run down and tired, what do you think is the source of these feelings?
- 3.) Are you taking any medications for heart disease, high blood pressure, or type II diabetes that you didn't have to take when you were younger?
- 4.) How do you explain the fact that you're in worse shape than when you were younger but haven't changed your habits at all?
- 5.) If you don't have anyone to exercise with regularly, are you willing to look for a physical activity partner?
- 6.) Are you willing to join a gym today?
- 7.) If someone told you that you'd need to throw away all the foods in your cupboards today and go shopping for different foods that are more appropriate to your goal, would you do it?

RESPONSES AND SCORING

- a.) Yes (+3)
 - b.) I'm not sure (0)
 - c.) No (-3)
-
- a.) Getting older (-1)
 - b.) My lifestyle choices (+3)
 - c.) Something else altogether (-3)
-
- a.) Yes, I'm on two or more medications (+3)
 - b.) Yes, I'm on only one medication (+1)
 - c.) No, I'm not on any medications (-3)
-
- a.) I think it's my family history (-1)
 - b.) I think it's that I'm less active (+3)
 - c.) I think it's a natural consequence of aging (-1)
 - d.) I don't know why it's happening (0)
-
- a.) Yes (+5)
 - b.) No (-5)
-
- a.) Yes (+3)
 - b.) No (-3)
-
- a.) Yes (+5)
 - b.) No (-5)



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READINESS FOR CHANGE QUESTIONNAIRE

- 8.) If an expert presents some information on diet and exercise that contradicts what you currently believe, what approach will you take?
- a.) Keep an open mind and give it a try (+3)
b.) Ask a friend (0)
c.) Ignore the advice (-3)
- 9.) Are you willing to have a meeting with your friends and loved one and share your behavior goals and desired outcomes with them?
- a.) Yes, right away (+5)
b.) Yes, but not just yet (-3)
c.) No (-5)
- 10.) If your work environment presents significant barriers to you exercising and eating well, would you consider speaking to your employer about changing some of these conditions or are you willing to find new employment?
- a.) Yes (+5)
b.) No (-5)
- 11.) Are you ready to spend less time with people who offer little or no social support for your goals while spending more time with those who do offer support?
- a.) Yes (+5)
b.) No (-5)
- 12.) Can you accept responsibility for the way your body is today and understand that, while your old habits don't make you a bad person, they still need to be changed?
- a.) Yes (+5)
b.) No (-5)
- 13.) If a friend or loved one suggests that you don't have what it takes to get into great shape because you've failed before or for some other reason, what will be your response?
- a.) I can do it (+2)
b.) I know I've got to make some changes but I'll take it one day at a time (+5)
c.) Maybe I can't do it (-5)
- 14.) Are you willing to wake up in the morning a bit earlier and stay up at night a bit later to accomplish your goals?
- a.) Yes (+5)
b.) No (-5)
- 15.) Are you willing to do at least five hours of physical activity each week?
- a.) Yes (+5)
b.) No (-5)

YOUR SCORE AND WHAT IT MEANS

21 to 63:

It's clear that changing the way you look, feel and perform have become very important to you and you realize that the way you're doing things right now simply isn't cutting it. You're tired of not getting results, and you're tired of your growing waistline, your sluggish metabolism and your lack of energy. And not only are you tired of it, you're committed to doing something about it—today. Congratulations! Getting to this point takes a lot of work. Now, let's do something about it.

-20 to +20:

If you scored in this range, it's important for you to stop thinking and start doing. You're probably frustrated with the way things are, but you're afraid that changing the way you do things will cause you more hassle and difficulty than just sitting back, doing nothing, and continuing to look and feel the way you do today. In fact, you're not alone. This is most people's greatest fear: that a new exercise and nutrition program will cause more pain than the pain they feel right now.



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If this is you, step outside of your shell and seek out some people who are exercising, eating well, getting results and having fun doing it. Clearly, millions of people out there are following a healthy lifestyle and loving every minute of it. But thinking that they never had difficulties to overcome like you do is a mistake. At some point in time each and every one of them had some old set of unproductive habits to discard. Once this was accomplished, they could easily get into the zone. And you can, too. What are you waiting for?

-61 to -21

From the results of your questionnaire, it doesn't look like you really want to change. Is this true? Are you simply toying with the idea of improving your physical activity habits and eating habits? If so, you're not really ready to make a change. With each passing year that you avoid good activity and nutrition habits your risk for disease increases. Not only that, you'll progressively gain fat, lose muscle, and look much older than your actual age. These are the consequences of remaining indifferent to the medications you're on, the weight you've gained and the environment with which you've surrounded yourself.

Are you ready to deal with these things? Don't stay indifferent any longer. Take an honest look at how you've changed (on the inside and out) and admit that you could use a tune-up.