DATA COLLECTION SHEET

NASM

NAME ______________________ DATE ______________

HEIGHT __________ WEIGHT __________ AGE __________

PHYSICIANS NAME ______________________ PHONE ______________

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

QUESTIONS

1. HAS YOUR DOCTOR EVER SAID THAT YOU HAVE A HEART CONDITION AND THAT YOU SHOULD ONLY PERFORM PHYSICAL ACTIVITY RECOMMENDED BY A DOCTOR?

YES __________ NO __________

2. DO YOU FEEL PAIN IN YOUR CHEST WHEN YOU PERFORM PHYSICAL ACTIVITY?

YES __________ NO __________

3. IN THE PAST MONTH, HAVE YOU HAD CHEST PAIN WHEN YOU WERE NOT PERFORMING ANY PHYSICAL ACTIVITY?

YES __________ NO __________

4. DO YOU LOSE YOUR BALANCE BECAUSE OF DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS?

YES __________ NO __________

5. DO YOU HAVE A BONE OR JOINT PROBLEM THAT COULD BE MADE WORSE BY A CHANGE IN YOUR PHYSICAL ACTIVITY?

YES __________ NO __________

6. IS YOUR DOCTOR CURRENTLY PRESCRIBING ANY MEDICATION FOR YOUR BLOOD PRESSURE OR FOR A HEART CONDITION?

YES __________ NO __________

7. DO YOU KNOW OF ANY OTHER REASON WHY YOU SHOULD NOT ENGAGE IN PHYSICAL ACTIVITY?

YES __________ NO __________

IF YOU HAVE ANSWERED “YES” TO ONE OR MORE OF THE ABOVE QUESTIONS, CONSULT YOUR PHYSICIAN BEFORE ENGAGING IN PHYSICAL ACTIVITY. TELL YOUR PHYSICIAN WHICH QUESTIONS YOU ANSWERED “YES” TO. AFTER A MEDICAL EVALUATION, SEEK ADVICE FROM YOUR PHYSICIAN ON WHAT TYPE OF ACTIVITY IS SUITABLE FOR YOUR CURRENT CONDITION.

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GENERAL& MEDICAL QUESTIONNAIRE

OCCUPATIONAL QUESTIONS

1. WHAT IS YOUR CURRENT OCCUPATION?

____

2. DOES YOUR OCCUPATION REQUIRE EXTENDED PERIODS OF SITTING?

YES ____________ NO ____________

3. DOES YOUR OCCUPATION REQUIRE EXTENDED PERIODS OF REPETITIVE MOVEMENTS? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

4. DOES YOUR OCCUPATION REQUIRE YOU TO WEAR SHOES WITH A HEEL (DRESS SHOES)?

YES ____________ NO ____________

5. DOES YOUR OCCUPATION CAUSE YOU ANXIETY (MENTAL STRESS)?

YES ____________ NO ____________

RECREATIONAL QUESTIONS

6. DO YOU PARTAKE IN ANY RECREATIONAL ACTIVITIES (GOLF, TENNIS, SKIING, ETC.)? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

7. DO YOU HAVE ANY HOBBIES (READING, GARDENING, WORKING ON CARS, EXPLORING THE INTERNET, ETC.)? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

MEDICAL QUESTIONS

8. HAVE YOU EVER HAD ANY PAIN OR INJURIES (ANKLE, KNEE, HIP, BACK, SHOULDER, ETC.)? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

9. HAVE YOU EVER HAD ANY SURGERIES? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

10. HAS A MEDICAL DOCTOR EVER DIAGNOSED YOU WITH A CHRONIC DISEASE, SUCH AS CORONARY HEART DISEASE, CORONARY ARTERY DISEASE, HYPERTENSION (HIGH BLOOD PRESSURE), HIGH CHOLESTEROL OR DIABETES? (IF YES, PLEASE EXPLAIN.)

YES ______________________________ NO ____________

11. ARE YOU CURRENTLY TAKING ANY MEDICATION? (IF YES, PLEASE LIST.)

YES ______________________________ NO ____________

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