

Pure Form PFT: Physical Activity Readiness Questionnaire (PAR-Q)

First Name: _____ Last Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: (_____) _____ Cell Phone(_____) _____ Birth Date: ____/____/____

EMAIL: _____ Gender: M/F Age: _____ Height: _____ Weight: _____

Date: _____ Fitness Professional: _____

Health History

Please read each question carefully. Initial in the space provided indicating that you understand what is recommended. Physical activity should not be hazardous for most people. The questions are designed to identify those who should consult a physician prior to beginning a program of physical exercise.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever said you have a heart condition and recommended medically supervised physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have chest pain brought on by physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you tend to lose consciousness, feel faint or have spells of dizziness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has your doctor recommended medication for blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bone or joint problem (such as arthritis) that could be aggravated by physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| Explain: | | |
| 6. Are you aware, through your own experiences or a doctor's advice, of any other physical reason against your exercising without medical supervision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Explain: | | |
| 7. Are you over the age of 65 and not accustomed to vigorous exercise? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES to one or more of the questions above, please answer and initial the following questions:

Have you consulted your physician regarding increasing your physical activity and or performing a fitness assessment?

Yes No **Initial** _____

If NO, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?

Yes No **Initial** _____

Please check all conditions that apply:

- | | | | |
|----------------------------|-------------------------|----------------------------------|--------------------------|
| ~ Heart Disease or Stroke | ~ Prostate Disease | ~ Gallbladder Disease | ~ Monitored by Physician |
| ~ High Blood Pressure | ~ Depression | ~ Low-back pain in last 6 months | ~ Recommended High- |
| ~ High Triglycerides | ~ Diabetes Mellitus | ~ Psychological Problems | Level Care |
| ~ Cancer | ~ Obesity | ~ Anorexia | ~ Special Diet |
| ~ Lung/Pulmonary Disease | ~ Arthritis | ~ Bulimia | ~ Other Medical |
| ~ Kidney Disease | ~ Anemia | ~ Compulsive Overeating | ~ _____ |
| ~ Osteoporosis | ~ Food Allergies | ~ Pregnant/Lactating/ Trying to | |
| ~ Ulcer | ~ Neuromuscular Disease | | |
| ~ Gastrointestinal Disease | ~ Arteriosclerosis | | |

Please list any medications you are currently taking below:

Notes:

Lifestyle Questions

Do you:

Eat 3 Meals Per Day: **YES** **NO**

Do you eat **5 servings** of **Yes** **No**
Fruits/Veggies a Day?

Do you Eat Fast Food: **Yes** **No**
How many times per week? _____

Drink Alcohol: **YES** **NO**

Eat Restaurant Food: **YES** **NO**
How many times per week? _____

Drink Coffee: **YES** **NO**

Smoke: **YES** **NO**

Eat Snacks: **YES** **NO**

Drink Soft Drinks **YES** **NO**

How many per day? _____

Watch TV: **YES** **NO**

How many hrs per day? _____

Take Supplements: **YES** **NO**

Get 7 Hrs. of Sleep Daily: **YES** **NO**

Are you Married: **YES** **NO**

Do you have Children: **YES** **NO**

Describe your occupation:

Describe your Hobbies: What do you like to do for Fun?

Goal Questions

What is your primary fitness goal?

Have you ever participated in a fitness program? Yes No If so, describe:

Did you get results? Yes No Describe:

Were results permanent? Yes No

On average, how long do you stick with a program before giving up?

What was your reason for quitting?

When did you first begin to think about getting in shape or getting back into shape?

What has prevented you from maintaining or achieving your fitness goals in the past?

When were you in the best shape of your life?

What do you weigh today? _____

What did you weigh 5 years ago? _____

What size do you wear today? _____

What size did you wear 5 years ago? _____

Rate your Motivation

1 2 3 4 5 6 7 8 9 10

For Staff Use Only

Body Fat Percentage: _____%

Goals:

Reasons:

Consequences:

RELEASE AND WAIVE OF LIABILITY

MEMBERS ACKNOWLEDGEMENT AND ASSUMPTION OF RISK AND FULL RELEASE FROM LIABILITY OF FIT SYSTEMS

Member acknowledges that the personal training/fitness assessment hereunder includes participation in strenuous physical activities, including but not limited to, aerobic movement, weight training, stationary bicycling, various aerobic conditioning machines and various nutritional programs offered by Pure Form PFT. Member agrees to assume all risk and responsibility involved with participation in the physical activities. Member affirms that he/she is in good physical condition and does not suffer from any disability that would prevent or limit participation in physical activities. Member acknowledges that participation will be physically and mentally challenging, and member agrees that it is the responsibility of the member to seek competent medical or other professional advice, regarding any concerns involved with the ability of member to take part in Pure Form PFT physical activities. Member agrees to assume all risks in responsibility for not exceeding his/her physical limits.

MEMBER SIGNATURE _____

Date _____