Core Restore
700 Asbury Avenue-Floor 1
Asbury Park, NJ 07712
732.502.0100

NAME: _____
DATE: _____ HEIGHT: _____in. WEIGHT: _____lbs.
AGE: _____ PHYSICIANS NAME: _____
PHONE: _____EMAIL: _____

PHYSICAL ACTIVITY READINESS QUESTIONAIRE (PAR-Q)

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest at rest, during your daily activities, or when you perform physical activity?		
3	Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? *please answer NO if your dizziness was associated with over-breathing (including vigorous exercise)		
4	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITIONS HERE:**_____		
5	Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) & MEDICATIONS HERE:**_____		
6	Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? **PLEASE LIST CONDITION(S) HERE:**_____		
7	Has your doctor ever said that you should only do medically supervised physical activity?		

If you answered NO to all of the questions above, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active—start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age.
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 years and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian, or care provider must also sign this form.

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 the community/fitness center 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_____

If you answered YES to one or more of the questions above, COMPLETE PAGES 3 & 4

Delay becoming more active if:

- ✓ You have a temporary illness such as a cold, or fever; it is best to wait until you feel better.
- ✓ You are pregnant- talk to your health care practitioner and/or your physician.
- ✓ Your health changes- answer the questions on Pages 3 & 4 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL COMDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c. ☐ If **NO**, go to question 2.

1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) ☐ YES ☐ NO

1b. Do you have joint problems causing pain, a recent fracture, or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? ☐ YES ☐ NO

1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? ☐ YES ☐ NO

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b. ☐ If **NO**, go to question 3.

2a. Does your Cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? ☐ YES ☐ NO

2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? ☐ YES ☐ NO

3. Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, and Diagnosed Abnormality of Heart Rhythm.*

If the above condition(s) is/are present, answer questions 3a-3d. ☐ If **NO,** go to question 4.

3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

3b. Do you have an irregular heart beat that requires medical management? (E.g. atrial fibrillation, premature ventricular contraction) ☐ YES ☐ NO

3c. Do you have chronic heart failure? ☐ YES ☐ NO

3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the past 2 months? ☐ YES ☐ NO

4. Do you have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b. ☐ If **NO**, go to question 5.

4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?

(Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

4b. Do you have a resting blood pressure equal to or greater than 160/90 mm/Hg with or without medication?
(Answer yes if you do not know your resting blood pressure) ☐ YES ☐ NO

5. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, and Pre-Diabetes*
If the above condition(s) is/are present, answer questions 5a-5e. ☐ If **NO**, go to question 6.

5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? ☐ YES ☐ NO

5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. YES NO

5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting eyes, kidneys, OR the sensation in your toes and feet? ☐ YES ☐ NO

5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? ☐ YES ☐ NO

5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?

☐ YES ☐ NO

6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome.*
If the above condition(s) is/are present, answer questions 6a-6b ☐ If NO, go to question 7.

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
(Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

6b. Do you have Down Syndrome AND back problems affecting nerves or muscles? ☐ YES ☐ NO

7. Do you have Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*
If the above condition(s) is/are present, answer questions 7a-7d. ☐ If **NO**, go to question 8.

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
(Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? ☐ YES ☐ NO

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? ☐ YES ☐ NO

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? ☐ YES ☐ NO

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c. ☐ If **NO**, go to question 9.

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? ☐ YES ☐ NO

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? ☐ YES ☐ NO

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event* If the above condition(s) is/are present, answer questions 9a-9c. ☐ If **NO**, go to question 10.

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments) ☐ YES ☐ NO

9b. Do you have any impairment in walking or mobility? ☐ YES ☐ NO

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? ☐ YES ☐ NO

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c ☐ If NO, read the Page 4 recommendations.

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months? ☐ YES ☐ NO

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? ☐ YES ☐ NO

10c. Do you currently live with two or more medical conditions? ☐ YES ☐ NO

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE:

_____

_____

_____

Please read the recommendations about your current medical condition(s) and sign the attached Participant Declaration:

If you answered NO to all of the FOLLOW-UP questions about your medical condition, you are ready to become more physically active—sign the Participant Declaration below:

- ✓ It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs
- ✓ You are encouraged to start slowly, and build up gradually—20-60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercise.
- ✓ As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- ✓ If you are over the age of 45 and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** talk to your doctor before you start becoming physically much more active or before you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered yes.

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

Delay becoming more active if:

- ✓ You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- ✓ You are pregnant—talk to your health care practitioner and/or your physician.
- ✓ Your health changes—talk to your doctor or qualified exercise professional before continuing with any physical activity program.

*You are encouraged to photocopy the PAR-Q. You must use the entire questionnaire and NO changes are permitted. The authors, the PAR-Q Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian, or care provider must also sign this form.

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 the community/fitness center 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 _____