

<b>Office use only:</b>	
Programme	
Venue	
Day & Time	
Staff member	



## Physical Activity Readiness Questionnaire (PAR-Q)

Name (BLOCK CAPITALS) \_\_\_\_\_

Please read the questions carefully and answer each one honestly: Tick, 'yes' or 'no'.

	YES	NO
Has a doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?		
Do you feel pain in your chest when you do physical activity?		
In the past month, have you had chest pain when you were not doing physical activity?		
Do you lose your balance because of dizziness or do you ever lose consciousness?		
Do you have a bone or joint problem that may be made worse by a change in your physical activity?		
Is your doctor currently prescribing drugs (for example Beta Blockers) for your blood pressure or heart condition?		
Do you know <u>of any other reason</u> why you should not do physical activity?		
Any other medical conditions that we should be aware of? Cancer, Asthma, diabetes etc.	Please specify	
Any other medical / health information that you would like to tell us?		

### **INFORMED CONSENT FOR EXERCISE PARTICIPATION**

**To be read and signed by the client:**

I understand that the purpose of this health programme is to provide safe and individualised exercise to improve health and fitness.

I understand that I am responsible for monitoring my own condition throughout the health programme and that should any unusual symptoms occur or if my health status changes, I will immediately cease my participation and inform the Exercise Adviser.

I accept that physical activity is involved in this health programme and that this carries risks.

I agree to be involved in the exercise programme and have received relevant information about the structure of this service, and data collected. I agree to be contacted for follow up purposes at regular intervals for up to 1 year. I understand that my data will be stored on paper and electronically on a secure database, in accordance with the Data Protection Act. I agree for my anonymised data to be shared by Legacy WM for evaluation purposes.

To the best of my knowledge, I have given all relevant information on my health and activity details. I consent to participate in this programme.

CLIENT		EXERCISE SPECIALIST	
Signature		Signature	
Print Name		Print Name	
Date		Date	