Account Number: ____________
☐ Month to Month ☐ 1 Year Commitment

PAR-Q/Health/Medical History Questionnaire

Name: ______________________________ DOB: ____________ Occupation: ____________
Home Phone: ________________________ Work Phone: ________________________
Emergency Contact: ______________________________ Phone: __________________

Are you currently taking any medications or drugs? Yes ____ No ____
If yes, please list any type, dose, and reason: ____

____

Does your Physician know you are participating in an exercise program? Yes ____ No ____

PAR-Q

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

YES NO

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

*If you answered "yes" to any of the above questions, we must have a Physician's release from you on file.
____(EMPLOYEE CHECK)

Health/Medical History

Please put a check next to any of the following conditions you have now or you have experienced in the past.

____ Heart attack, coronary bypass, or other cardiac surgery
____Stroke
____Low blood pressure
____Swollen, stiff or painful joints
____Arthritis
____Recent surgery (last 12 months)
____Pregnancy (now or within last 3 months)
____Increased blood cholesterol
____Epilepsy/seizures
____Diabetes
____High blood pressure
____Chest discomfort
____Hernia
____Unusual shortness of breath
____Lightheadedness or fainting
____Any chronic illness or condition
____Obesity (more than 20% over ideal body weight)

Please explain any checked boxes ____

____

<u>I affirm that the above information is true and accurate.</u>
Member Signature: ______________________________ Date: ____________

(STAFF USE ONLY: Exercise Specialist: ________________ Consultation Date: ___________)