PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Your comments and responses on the questionnaire are confidential and will be handled according to the ethical guidelines of the Canadian Society of Exercise Physiology (CSEP)

Name: _____

Address:

Street:_____

City/Province:_____

Postal Code:_____

Phone: _____

Email: _____

Date of Birth: _____

Age: _____ Sex: _____

Height: _____ Weight: _____

Occupation: _____

Emergency Contact Information:

Name:_____

Phone:_____ Relationship:_____

Signature: _____ Date:_____

1. RISKS ASSOCIATED WITH CARDIOVASCULAR PROBLEMS

	YES	NO
1.1 How long ago since you have seen a doctor?		
- less than 6 months	☐	☐
- 6 to 18 months (half a year to a year)	☐	☐
- more than 18 months (year and a half)	☐	☐
1.2 Has your doctor ever told you that you have a heart problem?	☐	☐
1.3 Do you experience chest or heart pains frequently?	☐	☐
1.4 Do you experience dizziness or weakness frequently?	☐	☐
1.5 Do you ever have palpitations, that is, your heart beating more rapidly for no reason?	☐	☐
1.6 Do you have bad headaches?	☐	☐
1.7 Are your ankles and/or knees often swollen (without being a result of an injury)?	☐	☐

Comments:

_____
_____
_____
_____
_____

2. RESPIRATORY SYSTEM

	YES	NO
2.1 Do you suffer from:		
- asthma	☐	☐
- bronchitis	☐	☐
- emphysema	☐	☐
- other respiratory sickness	☐	☐
- sleep apnea	☐	☐

*Specify*_____

3. METABOLIC PROBLEMS

	YES	NO
3.1 Within the past six months has your doctor said to you that:		
-you have hypertension	☐	☐
-you have type II diabetes	☐	☐
-you have impaired glucose tolerance	☐	☐
-you have hypercholesterolemia	☐	☐
-you have high triglycerides	☐	☐
-you have low HDL	☐	☐
-you are obese	☐	☐

*Others:*_____

4. LOCOMOTOR SYSTEM

	YES	NO
4.1 Has your doctor ever told you that you have bone or joint problems (such as arthritis for example) which might be worsened through exercise?	☐	☐
4.2 Do you suffer from:		
-frequent back pain	☐	☐
-hernia	☐	☐
-spinal cord problems/vertebral column problems	☐	☐
-problems with your meniscus (joints)	☐	☐
-ligament problems	☐	☐
-tendon problems	☐	☐

*Comments:*_____
_____
_____

5. RISKS ASSOCIATED WITH FAMILY PREDISPOSITION

	YES	NO
5.1 Are there any members of your family (parents, grandparents, brothers, sisters, aunts, uncles) who have:		
- suffered from chronic high blood pressure	☐	☐
*if yes, how many member(s)*_____		
- suffered from adult-onset diabetes	☐	☐
*if yes, how many member(s)*_____		
- suffered from juvenile diabetes	☐	☐
*if yes, how many member(s)*_____		
- died from a heart attack before the age of 60	☐	☐
*if yes, how many member(s)*_____		

*Comments:*_____
_____
_____

6. NEUROLOGICAL PROBLEMS

	YES	NO
6.1 Have you ever had a head injury or concussion?	☐	☐
- were you treated by a physician?	☐	☐
- were you hospitalized?	☐	☐
if yes, when _____		
- what were your symptoms? _____		
- how long did they last? _____		
6.2 Have you ever become unconscious or lost your memory?	☐	☐
6.3 Have you ever had a seizure?	☐	☐
6.4 Do you have frequent or severe headaches?	☐	☐

	YES	NO
6.5 Have you ever had tingling into your arms, hands, legs, or feet?	☐	☐
6.6 Have you ever had a nerve injury?	☐	☐

7. OTHERS/MISCELLANEOUS

	YES	NO
7.1 Have you had a major surgical operation within the past two years, or an illness requiring a stay in the hospital? *if yes, specify:* _____	☐	☐
7.2 Are you still suffering the operation or illness?	☐	☐
7.3 Do you feel ill?	☐	☐
7.4 Are there other physical reasons which would prevent you from following a physical exercise program even if you wanted to do so? *if yes, specify:* _____	☐	☐

8. PHYSICAL ACTIVITY AND EXERCISE HABITS

	YES	NO
Have you been physically active for one year or more?	☐	☐

If yes, indicate the number of minutes per week currently performing for each activity on the next page:

ACTIVITIES	**MINUTES/WEEK**	**ACTIVITIES**	**MINUTES/WEEK**
Dance	_____	Racquetball	_____
Folk Dance	_____	Tennis	_____
Canoeing	_____	Kayaking	_____
Climbing	_____	Martial Arts/Combative	_____
Squash	_____	Basketball	_____
Baseball/Softball	_____	Volleyball	_____
Soccer	_____	Running	_____
Hockey	_____	Ice Skating	_____
Badminton	_____	Bicycling	_____
Volleyball	_____	Swimming	_____
Curling	_____	Cross-Country Skiing	_____
Stationary Bicycle	_____	Downhill Skiing	_____
Jump Rope	_____	Diving	_____
Brisk Walking	_____	Rollerblading	_____
Rowing	_____	Sailing	_____
Wrestling	_____	Handball	_____
Snowshoeing	_____	Weight Training	_____

If the activities that you practice are not indicated in the list, please list them below and indicate the number of minutes a week.

ACTIVITIES	**MINUTES/WEEK**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Athletes:

Are you currently:

-resting Number of week(s): _____
-beginning training Number of week(s): _____
-competing Number of week(s): _____
-ill Number of week(s): _____

*Comments:*_____
_____
_____

9. **TOBACCO/TOXINS**

	YES	NO
9.1 Do you smoke?	☐	☐
9.2 Have you ever smoked?	☐	☐

If yes for question 9.1 or 9.2:

A – Cigarettes
How many do/did you consume in a day?

10 or less ☐ 20-30 ☐
20 or less ☐ 30 or more ☐

B – Pipe/Cigars
How often do/did you smoke pipes/cigars?

Occasionally ☐ Regularly ☐

C – For how many year(s) have you been smoking (or for how many years did you smoke)?

Less than a year ☐ 2-5 years ☐ More than 5 years ☐

D – If you used to smoke but don't smoke any longer, how many year(s) since you stopped?
_____ year(s)

10. **DIETARY HABITS**

	YES	NO
10.1 Do you make time to eat breakfast each morning?	☐	☐
10.2 Is it important for you to consume three meals each day?	☐	☐
10.3 Have you ever been instructed by a dietitian or receive nutritional counseling from another health care providers?	☐	☐
i*f yes, when*? _____		
10.4 Have you ever followed a diet program in the past?	☐	☐
if yes, when and what program? _____		

_____

_____

10.5 How many cup(s) of caffeine beverages (coffee and/or tea) do you consume each day?

2 or less ☐ 3-5 ☐ 6 or more ☐

10.6 Indicate the number of alcoholic beverage(s) you consume each week (beer, wine, spirits)?

Never Have ☐ Quit ☐ 1-2 ☐
3-6 ☐ 7-24 ☐ 25+ ☐

11. **STRESSORS**

	YES	NO
11.1 Is your profession or work liable to increase, in a potentially harmful way, your stress levels and make you irritable?	☐	☐
what is your profession/work? _____		
11.2 Do you have difficulty falling asleep or sleeping uninterrupted for at least 6 hours?	☐	☐

11.3 What is your average daily number of hours of sleep? _____

12. **WEIGHT**

12.1 In your opinion, is your weight 10 kg (25 lbs) or more above normal weight?	☐	☐
12.2 Do you have trouble gaining or losing weight?	☐	☐
12.3 Have you experienced any recent weight change?	☐	☐

13. **MEDICATIONS**

13.1 Do you take any medications regularly? (example: for high blood pressure)	☐	☐

if yes, specify: _____
_____
_____

14. **FOR WOMEN ONLY**

	YES	NO
14.1 Do you have gynecological problems which are heightened by physical activity?	☐	☐

if yes, specify: _____
_____
_____

14.2 Are you pregnant?	☐	☐

14.3 How many times have you been pregnant? _____

14.4 How many full-term pregnancies have you had? _____

14.5 Are you presently taking oral contraceptives?	☐	☐
14.6 Have you ever taken oral contraceptives?	☐	☐

14.7 If you answered yes to questions 14.5 and 14.6, for how long do/did you use them on a regular basis? _____ year(s)

14.8 If you have already used them in the past and no longer use them, how long ago did you stop?
_____ year(s)

	YES	**NO**
14.9 Are your menstrual cycles generally regular (between 25 and 35 days)?	☐	☐
if no, do they happen more frequently (less than 25 days between)?	☐	☐
or, do they happen less frequently (more than 35 days between)?	☐	☐
14.10 Are you menopausal?	☐	☐
if yes, for how long: _____ year(s)		
14.11 Have you experienced long periods without menstruating?	☐	☐

*Comments:*_____
_____
_____