HEALTH-HISTORY QUESTIONNAIRE

Name _____ Date _____

Age_____ Sex ❑ M ❑ F

Physician's Name_____Physician's Phone (_____)_____

Person to contact in case of emergency:
Name _____ Phone _____

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.

_____
_____
_____

Does your physician know you are participating in this exercise program?

_____

Describe any physical activity you do somewhat regularly.

_____
_____

Do you now have, or have you had in the past:	Yes	No
1. History of heart problems, chest pain, or stroke	❑	❑
2. Elevated blood pressure	❑	❑
3. Any chronic illness or condition	❑	❑
4. Difficulty with physical exercise	❑	❑
5. Advice from physician not to exercise	❑	❑
6. Recent surgery (last 12 months)	❑	❑
7. Pregnancy (now or within last 3 months)	❑	❑
8. History of breathing or lung problems	❑	❑
9. Muscle, joint, or back disorder, or any previous injury still affecting you	❑	❑
10. Diabetes or metabolic syndrome	❑	❑
11. Thyroid condition	❑	❑
12. Cigarette smoking habit	❑	❑
13. Obesity [body mass index (BMI) ≥30 kg/m^2]	❑	❑
14. Elevated blood cholesterol	❑	❑
15. History of heart problems in immediate family	❑	❑
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity	❑	❑

ACE
AMERICAN COUNCIL ON EXERCISE

2020 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

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.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do 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 during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND 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 answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be 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 Global Physical Activity Guidelines for your age (https://apps.who.int/iris/handle/10665/44399).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr 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 its 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 2 AND 3.

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, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

01-11-2019

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FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(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 chemotheraphy or radiotherapy)?	YES ☐	NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, 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 last 2 months?	YES ☐	NO ☐

4. Do you currently 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 mmHg 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, 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 your 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 ☐

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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 a 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, laboured 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: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) 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 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- 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 yr 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** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

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, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- 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+ or ePARmed-X+. 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 _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

Physician Referral for Client to Exercise

Date faxed:_____

Patient:_____ Patient's birth date:_____

Physician:_____ Physician's phone:_____

Physician's fax:_____ Physician's e-mail:_____

Dear Doctor,
Your patient has requested to participate in a structured exercise/physical-activity program at _____ _____. He or she has completed a pre-activity screening as part of his or her enrollment and, as a result of completing that pre-activity screening, has been identified as falling within a risk stratification (moderate-to-high risk) that requires physician clearance prior to engaging in a program of moderate physical activity. The client/patient has approved our forwarding this form to your attention, including the information that has resulted in their being identified as falling into a moderate-to-high risk stratification that requires physician approval before the client can begin participating in a program of moderate physical activity. The classification as moderate-to-high risk is based on the guidelines found in the American College of Sports Medicine's *ACSM's Guidelines for Exercise Testing and Prescription,* 7th edition (2006).

Coronary Risk Factors

- ❑ age (male >45, female >55)
- ❑ cigarette smoking
- ❑ elevated BP
- ❑ sedentary
- ❑ elevated blood lipid profile
- ❑ obesity (BMI >30)
- ❑ family history
- ❑ CV disease
- ❑ metabolic disease
- ❑ signs/symptoms
- ❑ pregnancy

Other relevant information: _____

_____

_____

Based on the information provided and any other information you, the physician have, your recommendations regarding the patient's participation in a program of moderate physical activity is:

- ❑ Patient/client is not cleared and cannot exercise at this time.
- ❑ Patient/client is cleared and can exercise with no restrictions.
- ❑ Patient/client is cleared with the following restrictions:

Physician's signature: _____ Date:_____

Please fax back to _____ at _____ within ten (10) days.

<u>Disclaimer</u>: This sample form is intended to be used for reference only. We advise you that any sample form must be reviewed, and possibly modified, with legal counsel prior to use.

<u>Testimonial and Photo Release Form</u>

In consideration of good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, I, the undersigned, hereby grant to _____("Trainer") and his/her agents the right to use my name, biographical information, photographs, images, story and/or testimonial, in whole or in part, and without restriction as to changes or alterations. The rights granted herein shall extend in perpetuity, unless revoked in writing to Trainer by me, throughout the world and for any purpose whatsoever, including without limitation for marketing and advertising purposes of Trainer, and in any and all media, including without limitation Trainer's website. I acknowledge that Trainer has no obligation to return any photographs or images to me.

I hereby RELEASE, WAIVE and FOREVER DISCHARGE any and all claims arising out of, or in connection with, such use by Trainer, including without limitation any and all claims for libel or invasion or privacy.

I hereby warrant and represent that I am at least 18 years of age and have the right to contract in my own name. I have read the above Release and am fully familiar with the contents thereof. This Release contains the entire agreement between the parties hereto as to the subject matter contained herein.

_____ _____

Signature Printed Name

_____

Date

Signature Parent/Guardian Signature (If under age of 18)

_____

Printed Name Parent/Guardian Printed Name (If under age of 18)

_____

Date

Personal Training Cancellation Policy

Clients must contact the trainer 24 hours in advance of cancelation.
If less than 24 hours the session may be rescheduled within that week at no charge.

Signature

_____

Date

_____

Waiver, Release, and Assumption of Risk Form

This form is an important legal document. It explains the risks you are assuming by beginning an exercise program. It is critical that you read and understand it completely. After you have done so, please print your name legibly and sign in the spaces provided at the bottom.

Waiver, Informed Consent, and Covenant Not to Sue

I,_____, have volunteered to participate in a program of physical exercise under the direction of (Ace Platinum Fitness), which will include, but may not be limited to, weight and/or resistance training. In consideration of (Ace Platinum Fitness) agreement to instruct, assist, and train me, I do here and forever release and discharge and hereby hold harmless (Ace Platinum Fitness), and their respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting therefrom. THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) EQUIPMENT THAT MAY MALFUNCTION OR BREAK (2) ANY SLIP, FALL, DROPPING OF EQUIPMENT AND (3) OUR NEGLIGENT INSTRUCTION OR SUPERVISION.

Assumption of Risk

I,_____, recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure; fainting; disorders in heartbeat; heart attack; and, in rare instances, death.

I understand that as a result of my participation in an exercise program, I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled and incapable of performing any gainful employment or having a normal social life.

I recognize that an examination by a physician should be obtained by all participants prior to involvement in any exercise program. If I,_____, have chosen not to obtain a physician's permission prior to beginning this exercise program with (Ace Platinum Fitness), I hereby agree that I am doing so at my own risk.

In any event, I acknowledge and agree that I assume the risks associated with any and all activities and/or exercises in which I participate.

I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. BY SIGNING THIS DOCUMENT, I AM WAIVING ANY RIGHT I OR MY SUCCESSORS MIGHT HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM AGAINST (Ace Platinum Fitness) FOR YOUR NEGLIGENCE OR THAT OF YOUR EMPLOYEES, AGENTS, OR CONTRACTORS.

_____ _____

Participant's signature Date

_____

Please print name