

CLUB FITNESS

THE PHYSICAL ACTIVITY READINESS QUESTIONNAIRE FOR EVERYONE

Regular physical activity is fun and healthy and more people should become more physically active every day of the week. Being more physically active 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.

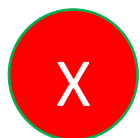
SECTION 1 – GENERAL HEALTH			
Please read the 7 questions below carefully and answer each one honestly: check YES or NO		YES	NO
1.	Has your doctor ever said that you have a heart condition OR high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you currently taking prescribed medications for a chronic medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, a knee, ankle, shoulder or other.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

If you answer NO to all of the questions above, you are cleared for physical activity.

Go to Section 3 to sign the form. You do not need to complete Section 2.



- Start becoming much more physically active – start slowly and build up gradually.
- You may take part in a health and fitness appraisal.
- If you have any further questions, contact a qualified exercise professional.
- If you are over the age of 45 years and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional before engaging in maximal effort exercise.



If you answered YES to one or more questions above, please GO TO SECTION 2.



Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better.
- You are pregnant- talk to your health care practitioner, your physician and/or a qualified exercise professional. Before becoming more physically active OR
- Your health changes – please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional before continuing with any physical activity programme.

SECTION 2 – CHRONIC MEDICAL CONDITIONS

Please read the questions below carefully and answer each one honestly: check YES or NO		YES	NO
1	Do you have Arthritis, Osteoporosis or Back Problems?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
2	Do you have Cancer of any kind? <u>(If yes answer questions 2a – 2b. If no, go to question 3)</u>	<input type="checkbox"/>	<input type="checkbox"/>
2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	<input type="checkbox"/>	<input type="checkbox"/>
2b.	Are you currently receiving cancer therapy (such as chemotherapy or radio therapy)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm. <u>If yes answer questions 3a – 3e. If no, go to question 4.</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial brillation, premature ventricular contraction)	<input type="checkbox"/>	<input type="checkbox"/>
3c.	Do you have chronic heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
3d.	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)	<input type="checkbox"/>	<input type="checkbox"/>
3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes. <u>If yes, answer questions 4a – 4c. if no, got to questions 5.</u>	<input type="checkbox"/>	<input type="checkbox"/>
4a.	Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure)	<input type="checkbox"/>	<input type="checkbox"/>
4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	<input type="checkbox"/>	<input type="checkbox"/>
4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	<input type="checkbox"/>	<input type="checkbox"/>
5	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) <u>If yes, answer questions 5a-5b. If no, go to questions 6.</u>	<input type="checkbox"/>	<input type="checkbox"/>
5a.	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)	<input type="checkbox"/>	<input type="checkbox"/>
5b.	Do you also have back problems affecting nerves or muscles?	<input type="checkbox"/>	<input type="checkbox"/>

Please read the questions below carefully and answer each one honestly: check YES or NO		YES	NO
6	Do you have a Respiratory Disease? 6. This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure. <u>If yes, answer questions 6a-6d. If no, go to question 7</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	<input type="checkbox"/>	<input type="checkbox"/>
6c.	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?	<input type="checkbox"/>	<input type="checkbox"/>
6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia. <u>If yes answer questions 7a-7c. If no, go to questions 8.</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	<input type="checkbox"/>	<input type="checkbox"/>
7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event. <u>If yes answer questions 8a – 8c. If no, go to question 9.</u>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
8b.	Do you have any impairment in walking or mobility?	<input type="checkbox"/>	<input type="checkbox"/>
8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions? <u>If yes, answer questions 9a – 9c. If no, read the advice on page 4.</u>	<input type="checkbox"/>	<input type="checkbox"/>
9a.	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?	<input type="checkbox"/>	<input type="checkbox"/>
9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	<input type="checkbox"/>	<input type="checkbox"/>
9c.	Do you currently live with two chronic conditions?	<input type="checkbox"/>	<input type="checkbox"/>

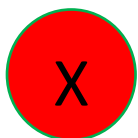
Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

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If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active:

- 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 min. 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 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional before engaging in maximal effort exercise.



If you answered YES to one or more of the follow-up questions about your medical condition:

- You should seek further information from a licensed health care professional before becoming more physically active or engaging in a fitness appraisal and/or visit a or qualified exercise professional for further information.



Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, before becoming more physically active OR
- Your health changes - please talk to your doctor or qualified exercise professional before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy this questionnaire. You must use the entire questionnaire and NO changes are permitted.
- Club Fitness and its agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity. 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.
- Please read and sign the declaration below:

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 a Trustee (such as my employer, community/fitness centre, healthcare provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____