

Physical Activity Readiness Questionnaire (PAR Q)

Long version



The Register of
Exercise Professionals

When using this form, you need to state:

Why you are collecting this information.

What you are going to do with this information (how you will store this).

Your policy for destroying this information (within a period of time or once the client has left).

Your Personal Details

Client Name: _____ DoB: _____

Address: _____

Postcode: _____

Email: _____ Phone: _____

Emergency Contact Details

Name: _____

Address: _____

Postcode: _____

Email: _____ Phone: _____

Your Health Goals

1. What health goals would you like to achieve in the next 3 months?

2. Name 3 things you could do in order to improve your health?

What are your main reasons for starting a fitness programme?

General conditioning ☐

Muscular strength ☐

No time ☐

Weight /fat loss ☐

Aerobic fitness ☐

Appearance ☐

Stress management ☐

Flexibility ☐

Improve self-esteem ☐

Other ☐

How would you describe your general health and fitness?

Have you ever done any structured exercise?

Yes / No

If 'Yes' what did you do? _____

What type of exercise do you enjoy the most? _____

What type of exercise do you dislike the most? _____

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What would you say are the main barriers preventing you from exercising?

Lack of facilities	☐	No motivation	☐	No time	☐
Injury/illness	☐	Unfit	☐	Appearance	☐
Lack of knowledge	☐	Family	☐	Work	☐

Diet and Nutrition

On a scale of 1-10 (**with 1 being poor and 10 being excellent**) how would you assess the quality of your eating habits?

Would you like any help or advice in changing the quality of your eating habits? **Yes / No**

Do you follow any particular diet or eating patterns?

Lifestyle

Do you drink alcohol? **Yes / No**

Do you smoke? **Yes / No**

If you answered 'Yes', would you like help or advice to change these habits? **Yes / No**

Medical History

Have you had a major illness or injury in the last 5 years **Yes / No**

If 'Yes' please give details _____

Are you receiving treatment for any diagnosed medical condition? **Yes / No**

If 'Yes' please give details _____

Are you taking any prescription medication? **Yes / No**

If 'Yes' please give details _____

Please indicate if you ever experience any of the following symptoms. Do you:

Ever get unusually short of breath with very light exertion?	☐	☐
Ever have pain, pressure, heaviness or tightness in the chest area?	☐	☐
Regularly have unexplained pain in the abdomen, shoulders or arm?	☐	

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Please indicate if you ever experience any of the following symptoms. Do you:

- | | | |
|--|--------------------------|--------------------------|
| Ever have severe dizzy spells or episodes of fainting? | ☐ | ☐ |
| Regularly get lower leg pain during walking that is relieved by rest? | ☐ | ☐ |
| Ever experience palpitations or irregular heartbeats? | ☐ | ☐ |
| Are you currently pregnant or have you given birth in the last 6 months? | Yes / No | |

Structural Health

Please indicate on the figures below any aches, pains or problem areas.

Please give details of any areas indicated

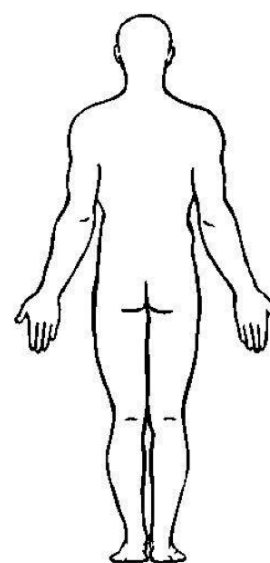
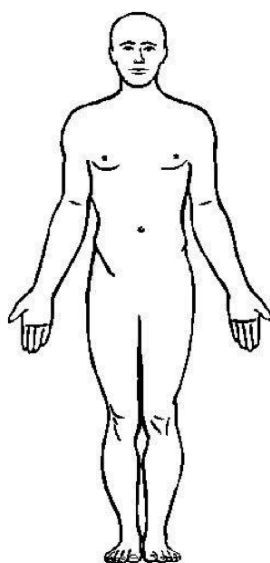
Are any of these injuries aggravated by exercise?

Yes / No

Are you currently receiving treatment for any structural problem?

Yes / No

Please indicate any other health problems you suffer from which you have not already mentioned.



I can confirm that I have answered all questions honestly and that the information given is correct.

Signature: _____ Print name: _____ Date: _____

Note: This PAR Q becomes invalid should your condition change.