Physical Activity Readiness Questionnaire (PAR Q) Long version

REPs
The Register of Exercise Professionals
PART OF THE SKILLSACTIVE GROUP

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

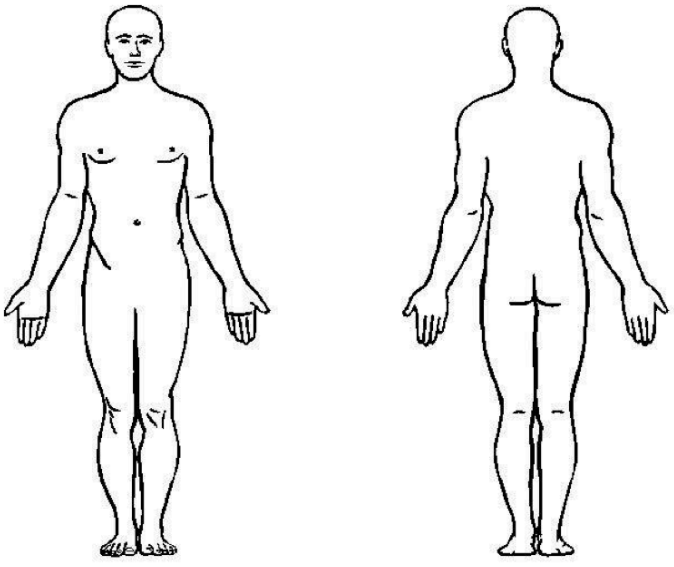
Please indicate on the figures below any aches, pains or problem areas.

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: _____