



Physical Readiness Activity Questionnaire (PAR-Q)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below.

If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor. Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

Yes No Do you feel pain in your chest when you do physical activity?

Yes No In the past month, have you had chest pain when you were not doing physical activity?

Yes No Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes No Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes No Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

Yes No Do you know of any other reason why you should not do physical activity?

If You Answered Yes

If you answer yes to one or more PAR-Q questions, please continue onto the PAR-Q+, which is a series of 10 follow-up questions. These more in-depth questions ask about whether you have specific health conditions, such as arthritis and cancer.

If You Answered No

If you answered no to all the PAR-Q questions, you can be reasonably sure that you can exercise safely and have a low risk of having any medical complications from exercise. It is still important to start slowly and increase gradually. It may also be helpful to have a fitness assessment with a personal trainer or coach in order to determine where to begin.

By signing and submitting this form, I attest that it is correct to the best of my knowledge.

Signature*:

Date:

Printed Name:

Email:

*If submitting online, please type in your name which will substitute as a digital signature



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#	Questionnaire	Yes	No
1	Do you have Arthritis, Osteoporosis, or Back Problems? <i>If the above condition(s) is/are present, answer questions 1a – 1c</i>		
1a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
1b	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancers, displaced vertebra (e.g. spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?		
1c	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?		
2	Do you currently have cancer of any kind? <i>If the above condition(s) is/are present, answer questions 2a-2b</i>		
2a	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?		
2b	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?		
3	Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure and/or Diagnosed Abnormality of Heart Rhythm? <i>If the above condition(s) is/are present, answer questions 3a-3d</i>		
3a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
3b	Do you have an irregular heart beat that requires medical management? (e.g. atrial fibrillation, premature ventricular contraction)		
3c	Do you have Chronic Heart Failure?		
3d	Do you have diagnosed Coronary Artery (cardiovascular) Disease and have not participated in regular physical activity in the last 2 months?		
4	Do you currently have High Blood Pressure? <i>If the above condition(s) is/are present, answer questions 4a – 1b</i>		
4a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
4b	Do you have a resting blood pressure equal to or greater than 160/90 mm HG with or without medication? Answer YES if you do not know your resting blood pressure.		
5	Do you have any Metabolic Conditions? This includes Type I/Type 2 Diabetes/ Pre-Diabetes If the above conditions(s) is/are present answer questions 5a-5d.		
5a	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician prescribed therapies?		
5b	Do you 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?		
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?		
5d	Do you have other metabolic conditions such as current pregnancy-related diabetes, chronic kidney disease, or liver problems?		



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#	Questionnaire	Yes	No
6	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer’s, Dementia, Depressions, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome? <i>If the above condition(s) is/are present, answer questions 6a -6b</i>		
6a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
6b	Do you have Down Syndrome AND back problems affecting nerves or muscles?		
7	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma and/or Pulmonary High Blood Pressure. <i>If the above condition(s) is/are present, answer questions 7a-7d</i>		
7a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
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?		
7c	If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?		
7d	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?		
8	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia. <i>If the above condition(s) is/are present, answer questions 8a-8c</i>		
8a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
8b	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?		
8c	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?		
9	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event? <i>If the above condition(s) is/are present, answer questions 9a – 9c</i>		
9a	Do you have difficulty controlling your condition with medications or other physician prescribed therapies? Answer NO if you are not currently taking medications		
9b	Do you have any impairment in walking or mobility?		
9c	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?		
10	Do you have any other medical condition not listed above or do you have two or more medical conditions noted above? <i>If you have other medical conditions, answer questions 10a – 10b</i>		
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 with the last 12 months?		
10b	Do you have a medical condition that is not listed? Please enter them here		



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

You should seek further information before becoming more physically active or engaging in a fitness appraisal. *It is recommended that you visit a qualified exercise professional (with advanced university training) or your family physician for further information.* This does not mean that you cannot perform any physical activities. We recommend that you only engage in low-intensity physical activity until you have received clearance from your physician and/or have met with a qualified exercise professional.

If you answered NO to all of the questions about your medical condition, you are ready to become more physically active with the following recommendations:

- If you are over the age of 45 and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- You are encouraged to start slowly and build up gradually to 20 – 60 minutes of moderate intensity exercise, 3-5 days per week.
- Your exercise program should be tailored to your specific needs and should include a combination of aerobic, agility and muscle strengthening exercises.

I, the undersigned, have read, understood to my full satisfaction and completed the PAR-Q+ Form. I have answered each question truthfully, reflecting my current condition. I acknowledge that this physical activity clearance/recommendation is valid for a maximum of 6 months from the date it is completed and becomes invalid if my condition changes.

Signature*:

Date:

Printed Name:

Email:

*If submitting online, please type in your name which will substitute as a digital signature