



PARQ & YOU

Name _____

Date _____

(A QUESTIONNAIRE FOR PEOPLE AGED 15 TO 69)

PAR-Q is designed to help you help yourself. Many health benefits are associated with regular exercise and the completion of PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people, physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate, or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these few questions. Please read them carefully and check (✓) the YES or NO opposite the question as it applies to you.

YES NO

- 1. Has your doctor ever said that you have a heart condition **and** that you should only do physical activity recommended by a doctor?
- 2. Do you feel pain in your chest when you do physical activity?
- 3. In the past month, have you had chest pain when you were not doing physical activity?
- 4. Do you lose your balance because of dizziness, or do you ever lose consciousness?
- 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- 6. Are you currently taking any prescription drugs?
- 7. Do you know of **any other reason** why you should not do physical activity?

IF YOU ANSWERED . . .

YES to one or more questions

Consult with your personal physician BEFORE increasing your physical activity and/or taking a fitness appraisal.

- * Tell your physician what questions you answered YES to on PAR-Q or present this PAR-Q copy.
- * If you will be seeing a fitness professional, please have your physician complete the medical clearance request on the back of this form.

NO to all questions

If you answered NO honestly to **all** PAR-Q questions, you have reasonable assurance that you can:

- * Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- * Take part in a fitness assessment – this is an excellent way to determine your basic fitness so you can plan the best way to live actively.

DELAY BECOMING MUCH MORE ACTIVE:

- * If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- * If you are or may be pregnant – talk to your doctor before you start becoming more active.

Please note: If your health changes so you would answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.



MWR-JBPHH HAWAII FITNESS CENTERS MEDICAL CLEARANCE REQUEST

Check your training location:

- | | | |
|---|--|---|
| <input type="checkbox"/> JBPHH Fitness Center, 471-2019 | <input type="checkbox"/> Ford Island Gym | <input type="checkbox"/> Hickam AFB, 448-2214 |
| <input type="checkbox"/> Kunia Gym | <input type="checkbox"/> Makalapa Gym | <input type="checkbox"/> NAVSTA Gym |
| <input type="checkbox"/> Wahiawa Annex, 653-5542 | <input type="checkbox"/> West Loch | |

Your patient _____ has requested to participate in an exercise-training program, which would include:

- **A fitness assessment to measure muscle strength and endurance, cardiovascular fitness level, posture and flexibility.**
- **An exercise program 3 times per week, with each session lasting approximately 1 hour.**

The American College of Sports Medicine recommends that a man over age 45, or a woman over age 55, who has not exercised on a regular basis receive an exercise stress test prior to exercise.

Does your patient require a diagnostic test prior to beginning his/her program?

- Yes No

My patient _____ is able to participate in an exercise assessment and an exercise program.

My patient _____ is not able to participate in an exercise assessment and an exercise program.

These restrictions or exercise limitations should be followed:

This patient is taking medications that will affect heart rate or other parameters during exercise.

Type of medication	Effect
_____	_____
_____	_____
_____	_____

Physician's Signature _____ Date _____

Physician's Phone # _____ (You may be contacted for more info.)

Received by _____ Date _____
(Fitness Specialist's/Trainer's Signature)