Pilates GALS
GROWTH ADVENTURE LOVE STRENGTH

# Physical Activity Readiness Questionnaire

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.
**Complete the fields on this form, sign it, save it, and send a copy to admin@pilatesgals.com**

## GENERAL HEALTH QUESTIONS

**Please read the 7 questions below carefully and answer each one honestly: check YES or NO.**

1) Has your doctor ever said that you have a heart condition?
☐ YES ☐ NO

2) Has your doctor ever said that you have high blood pressure?
☐ YES ☐ NO

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).
☐ YES ☐ NO

4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?
☐ YES ☐ NO
***Please list condition(s) here:***

_____

5) Are you currently taking prescribed medications for a chronic medical condition?
☐ YES ☐ NO
***Please list condition(s) here:***

_____

6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active.
☐ YES ☐ NO
***Please list condition(s) here:***

_____

7) Has your doctor ever said that you should only do medically supervised physical activity?

☐ YES ☐ NO

If you answered **NO** to **all** the questions above, you are cleared for physical activity. Please sign the **Participant Declaration** at the bottom of this page.

You do not need to complete the Follow-up Questions About Your Medical Conditions(s)**.**

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age.
  ( https://apps.who.int/iris/handle/10665/44399 )
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

If you answered **YES** to one or more of the questions above, complete the Follow-up Questions About Your Medical Conditions(s) below.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, and/or qualified exercise professional before becoming more physically active.
- Your health changes - answer the questions below under **Follow-up Questions About Your Medical Conditions(s)** and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

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**Follow-up Questions About Your Medical Conditions(s)**

***8) Do you have Arthritis, Osteoporosis, or Back Problems?***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 8a-8c. If **NO** go to question 9.

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)

☐ YES ☐ NO

8b) 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)?

☐ YES ☐ NO

8c) Have you had steroid injections or taken steroid tablets regularly for more than 3 months?

☐ YES ☐ NO

***9) Do you currently have Cancer of any kind?***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 9a-9b. If **NO** go to question 10.

9a) Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?

☐ YES ☐ NO

9b) Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?

☐ YES ☐ NO

***10) Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 10a-10d. If **NO** go to question 11.

10a) 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)

☐ YES ☐ NO

10b) Do you have an irregular heartbeat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)

☐ YES ☐ NO

10c) Do you have chronic heart failure?

☐ YES ☐ NO

10d) Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?

☐ YES ☐ NO

**11) Do you currently have High Blood Pressure?**

☐ **YES** ☐ **NO**

If the above condition(s) is/are present, answer questions 11a-11b. If **NO** go to question 12.

11a) 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)

☐ YES ☐ NO

11b) 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)

☐ YES ☐ NO

***12) Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 12a - 12e. If **NO** go to question 13.

12a) Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician- prescribed therapies?

☐ YES ☐ NO

12b) Do you often 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.

☐ YES ☐ NO

12c) 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?

☐ YES ☐ NO

12d) Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?

☐ YES ☐ NO

12e) Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?

☐ YES ☐ NO

***13) 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***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 13a - 13b. If **NO** go to question 14.

13a) 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)

☐ YES ☐ NO

13b) Do you have Down Syndrome AND back problems affecting nerves or muscles?

☐ YES ☐ NO

***14) Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 14a - 14d. If **NO** go to question 15.

14a) 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)

☐ YES ☐ NO

14b) Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?

☐ YES ☐ NO

14c) 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?

☐ YES ☐ NO

14d) Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?

☐ YES ☐ NO

***15) Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 15a - 15c. If **NO** go to question 16.

15a) 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)

☐ YES ☐ NO

15b) Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?

☐ YES ☐ NO

15c) Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysretlexia)?

☐ YES ☐ NO

***16) Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 16a - 16c. If **NO** go to question 17.

16a) 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)

☐ YES ☐ NO

16b) Do you have any impairment in walking or mobility?

☐ YES ☐ NO

16c) Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?

☐ YES ☐ NO

***17) Do you have any other medical condition not listed above or do you have two or more medical conditions?***

☐ ***YES*** ☐ ***NO***

If the above condition(s) is/are present, answer questions 17a - 17c. If **NO** go to **Recommendations**

17a) 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?

☐ YES ☐ NO

17b) Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?

☐ YES ☐ NO

17c) Do you currently live with two or more medical conditions?

☐ YES ☐ NO

***Please list your medical condition(s) here:***

***And any related medications here:***

**Recommendations**

If you answered **NO** to ALL of the **Follow-up Questions About Your Medical Conditions(s)**, you are ready to become more physically active - sign the **Participant Declaration** below:

- 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 to 60 minutes 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 yr. and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:
You should seek further information before becoming more physically active or engaging in a fitness appraisal.

**Delay becoming more active if:**

- You have a temporary illness such as a cold or fever; it is best to 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.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted. **Evangeline Brouwer and Pilates GALS, and all parties directly and indirectly,** assumes no liability for persons who undertake physical activity and/or make use of the **Physical Activity Readiness Questionnaire**. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

***Participant Declaration***

All persons who have completed the **Physical Activity Readiness Questionnaire** please read and sign the declaration below.

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.

☐ **YES**, 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 the Owner, Director, Evangeline Brouwer may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

_____
FULL NAME

_____
DATE

_____
EMAIL

_____
SIGNATURE