



The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from a qualified exercise professional OR your doctor before becoming more physically active.

GENERAL HEALTH QUESTIONS

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

1. Has your doctor ever said that you have a heart condition OR high blood pressure?
Answer: Yes No
2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity? Answer: 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). Answer: Yes No
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? Please list condition(s) here:

Answer: Yes No

5. Are you currently taking prescribed medications for a chronic medical condition? Please list condition(s) and medications here:

Answer: Yes No

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. Please list condition(s) here:

Answer: Yes No

7. Has your doctor ever said that you should only do medically supervised physical activity? Answer: Yes No





If you answered NO to all of the questions above, you are cleared for physical activity.

You do not need to complete the follow-up questions.

You are encouraged to:

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
- Take part in a health and fitness appraisal if you wish.
- If you are over the age of 45 years and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- Contact a qualified exercise professional if you have any further questions.

PARTICIPANT DECLARATION

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.

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 community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name: _____ Date: _____

Signature of participant: _____

Witness: _____

Signature of parent/guardian/care provider (if applicable): _____

If you answered YES to one or more of the general health questions (1 to 7) above, complete the FOLLOW-UP QUESTIONS of this document.

Delay becoming more active if any of the following apply:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Answer the follow-up questions of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.



**FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)****1. Do you have Arthritis, Osteoporosis, or Back Problems?**

If the above condition(s) is/are present, answer questions 1a to 1c. If NO, go to question 2.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. 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)? Answer: Yes No
- c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? Answer: Yes No

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a and 2b. If NO, go to question 3.

- a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? Answer: Yes No
- b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? Answer: Yes No

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

If the above condition(s) is/are present, answer questions 3a to 3d. If NO, go to question 4.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. Do you have an irregular heartbeat that requires medical management (e.g., atrial fibrillation, premature ventricular contraction)? Answer: Yes No
- c. Do you have chronic heart failure? Answer: Yes No
- d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?
Answer: Yes No



**4. Do you currently have High Blood Pressure?**

If the above condition is present, answer questions 4a and 4b. If NO, go to question 5.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. 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.) Answer: Yes No

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, and Pre-Diabetes.

If the above condition(s) is/are present, answer questions 5a to 5e. If NO, go to question 6.

- a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? Answer: Yes No
- b. 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. Answer: Yes No
- c. 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? Answer: Yes No
- d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? Answer: Yes No
- e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? Answer: Yes No

6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, and Down Syndrome.

If the above condition(s) is/are present, answer questions 6a and 6b. If NO, go to question 7.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. Do you have Down Syndrome AND back problems affecting nerves or muscles? Answer: Yes No





7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, and Pulmonary High Blood Pressure.

If the above condition(s) is/are present, answer questions 7a to 7d. If NO, go to question 8.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?
Answer: Yes No
- c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, or a consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?
Answer: Yes No
- d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? Answer: Yes No

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia.

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

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? Answer: Yes No
- c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? Answer: Yes No

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

If the above condition is present, answer questions 9a to 9c. If NO, go to question 10.

- a. Are you currently taking medication or treatment for this condition, and still having trouble keeping it under control? (If you are not on any treatment or medication, please answer NO.) Answer: Yes No
- b. Do you have any impairment in walking or mobility? Answer: Yes No
- c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? Answer: Yes No





10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If the above condition(s) is/are present, answer questions 10a to 10c. If NO, read the recommendations on the next page.

- a. 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? Answer: Yes No
- b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, or kidney problems)? Answer: Yes No
- c. Do you currently live with two or more medical conditions?
Answer: Yes No

Please list your medical condition(s) and any related medications here:





RECOMMENDATIONS BASED ON YOUR FOLLOW-UP RESPONSES

If you answered **NO** to all of the **FOLLOW-UP** questions (questions 1a to 10c) about your medical condition, 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 to 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 years 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. You should complete the specially designed online screening and exercise recommendations program — the ePARmed-X+ at www.eparmedx.com — and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if any of the following apply:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.





PARTICIPANT DECLARATION FOR CLIENTS COMPLETING FOLLOW-UP QUESTIONS

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.

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 community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name: _____ Date: _____

Signature of participant: _____

Witness: _____

Signature of parent/guardian/care provider (if applicable): _____

For more information, please visit: www.eparmedx.com

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Key references:

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