

Health and safety questionnaire - PAR-Q

Name: _____ Telephone: _____
Address: _____
Occupation: _____ Age: _____ Male/Female

Medical history

1. Have you ever suffered from heart trouble? YES / NO
2. Are you presently taking any form of medication? YES / NO
3. Do you suffer from chest pains? YES / NO
4. Do you ever have spells of dizziness or feel faint? YES / NO
5. Have you ever had either high or low blood pressure, and/or high cholesterol level? If YES please indicate which: YES / NO
6. Have you ever had asthma, chronic bronchitis or any other chest ailments? If YES Please indicate which: YES / NO
7. Do you suffer from back pain or any orthopaedic problem? If YES please indicate which: YES / NO
8. Do you suffer from severe headaches or migraines? YES / NO
9. Are you recuperating from a recent illness/operation or injury? If YES please expand: YES / NO
10. Have you any medical condition that we should be aware of? YES / NO
11. Are you pregnant? If yes, how many months? YES / NO
12. Is there any history of heart disease in your immediate family (under the age of 55)? YES / NO

PLEASE NOTE: If you answered YES to any of questions 1-12, you are advised to seek medical advice/approval before commencing an exercise induction or exercise programme or consult further with your instructor.

I have been informed both verbally and in writing that if I answer YES to any of questions 1-12 of this questionnaire, I should seek medical advice/approval before commencing an exercise programme and/or induction. If I wish to continue without such advice I do so entirely at my own risk. I confirm that I have read, fully understood and answered the above questions honestly. I understand that the Centre and any of its employees cannot be held responsible for any injuries or ill health arising from my participation in the exercise programme.

Signed: _____ Date: _____ Consultant: _____