



AGREEMENT PLAN:

__Community__

CENTER FOR HEALTH AND WELLNESS

Physical Activity and Readiness Questionnaire (PAR-Q)

CLIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: Male Female

Phone #: _____ Email: _____

Emergency Contact Name & Phone: _____

How did you hear about us? (Check) ☐ Employee ☐ Physician ☐ Physical Therapy ☐ Family or Friend ☐ Google
☐ Social Media (i.e. Facebook) ☐ Word of Mouth ☐ AdventHealth Website

Renew Active / Silver Sneakers / Prime ID / Active & Fit / Silver & Fit Fitness ID: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____

GOALS/INTERESTS

Please list: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS by checking the appropriate box:

- | | |
|--|--|
| 1. Has your Physician ever said that you have a heart condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you feel pain in your chest or arms when you do physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you had chest or arm pain when you were not doing physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you ever feel faint or lose your balance, get dizzy or pass out? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you have high blood pressure that is not being treated medically? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you take medicine for your blood pressure or heart condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever had a blood clot? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Are you taking blood thinning medications, including aspirin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you have a respiratory problem, COPD, or Asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Do you have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Bone or joint problem that could worsen with physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Are you pregnant or have been within three months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Is there any other reason why you should not do physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Has your Physician ever restricted you from exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you have answered **three (3) or more questions YES**, you must obtain medical clearance from your Physician prior to engaging in physical exercise at the AdventHealth Daytona Beach Center for Health and Wellness. We will provide a form for you to use for this purpose. We advise all participants to consult with their Physician prior to exercise. Guests under the age of 18 years must be accompanied by an adult.

Signature _____

Date _____



Parental Signature (required for participant under age 18)