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 your doctor OR a qualified exercise professional before becoming more physically active.

### GENERAL HEALTH QUESTIONS

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

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Has your doctor ever said that you have a heart condition □ OR high blood pressure □?</td>
<td></td>
<td></td>
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<tr>
<td>2) Do you feel pain in your chest at rest, during your daily activities of living, <strong>OR</strong> when you do physical activity?</td>
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<tr>
<td>3) Do you lose balance because of dizziness <strong>OR</strong> have you lost consciousness in the last 12 months? Please answer <strong>NO</strong> if your dizziness was associated with over-breathing (including during vigorous exercise).</td>
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<tr>
<td>4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? <strong>PLEASE LIST CONDITION(S) HERE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Are you currently taking prescribed medications for a chronic medical condition? <strong>PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 <strong>NO</strong> if you had a problem in the past, but it <strong>does not limit your current ability</strong> to be physically active. <strong>PLEASE LIST CONDITION(S) HERE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Has your doctor ever said that you should only do medically supervised physical activity?</td>
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</tbody>
</table>

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

**Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- 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 PAGES 2 AND 3.**

**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, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.
1. Do you have Arthritis, Osteoporosis, or Back Problems?  
If the above condition(s) is/are present, answer questions 1a-1c  
If NO go to question 2

1a. 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

1b. 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

1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?  
YES NO

2. Do you currently have Cancer of any kind?  
If the above condition(s) is/are present, answer questions 2a-2b  
If NO go to question 3

2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?  
YES NO

2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?  
YES NO

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm  
If the above condition(s) is/are present, answer questions 3a-3d  
If NO go to question 4

3a. 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

3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)  
YES NO

3c. Do you have chronic heart failure?  
YES NO

3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?  
YES NO

4. Do you have High Blood Pressure?  
If the above condition(s) is/are present, answer questions 4a-4b  
If NO go to question 5

4a. 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

4b. 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

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes  
If the above condition(s) is/are present, answer questions 5a-5e  
If NO go to question 6

5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?  
YES NO

5b. 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

5c. 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

5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?  
YES NO

5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?  
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, Down Syndrome
   If the above condition(s) is/are present, answer questions 6a-6b
   If NO ☐ go to question 7

6a. 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 ☐

6b. Do you have Down Syndrome AND back problems affecting nerves or muscles?
   YES ☐ NO ☐

7. **Do you have a Respiratory Disease?** This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure
   If the above condition(s) is/are present, answer questions 7a-7d
   If NO ☐ go to question 8

7a. 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 ☐

7b. 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 ☐

7c. 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 ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?
   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-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 commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?
   YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?
   YES ☐ NO ☐

9. **Have you had a Stroke?** This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event
   If the above condition(s) is/are present, answer questions 9a-9c
   If NO ☐ go to question 10

9a. 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 ☐

9b. Do you have any impairment in walking or mobility?
   YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?
   YES ☐ NO ☐

10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**
    If you have other medical conditions, answer questions 10a-10c
    If NO ☐ read the Page 4 recommendations

10a. 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 ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?
    YES ☐ NO ☐

10c. Do you currently live with two or more medical conditions?
    YES ☐ NO ☐

**PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE:**

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**GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.**
2017 PAR-Q+

PARTICIPANT DECLARATION

NAME  ____________________________________________________

SIGNATURE ________________________________________________

You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.

The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

All persons who have completed the PAR-Q+ 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.

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 a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the information is protected and used only for the purposes for which it was collected.

NAME ____________________________________________________

SIGNATURE ________________________________________________

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER ____________________________________________________

DATE ________________________________

WITNESS ____________________________________________________

For more information, please contact

www.eparmedx.com
Email: eparmedx@gmail.com

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gleddhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References


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