

# Physical Activity Readiness Questionnaire (PAR Q) Long version



The Register of  
Exercise Professionals

## When using this form, you need to state:

Why you are collecting this information.

What you are going to do with this information (how you will store this).

Your policy for destroying this information (within a period of time or once the client has left).

## Your Personal Details

Client Name: \_\_\_\_\_ DoB: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Contact Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## Your Health Goals

1. What health goals would you like to achieve in the next 3 months?

\_\_\_\_\_

2. Name 3 things you could do in order to improve your health?

\_\_\_\_\_

## What are your main reasons for starting a fitness programme?

General conditioning  Muscular strength  No time

Weight /fat loss  Aerobic fitness  Appearance

Stress management  Flexibility  Improve self-esteem

Other

## How would you describe your general health and fitness?

\_\_\_\_\_

## Have you ever done any structured exercise?

Yes / No

If 'Yes' what did you do? \_\_\_\_\_

What type of exercise do you enjoy the most? \_\_\_\_\_

What type of exercise do you dislike the most? \_\_\_\_\_



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## What would you say are the main barriers preventing you from exercising?

- |                    |                          |               |                          |            |                          |
|--------------------|--------------------------|---------------|--------------------------|------------|--------------------------|
| Lack of facilities | <input type="checkbox"/> | No motivation | <input type="checkbox"/> | No time    | <input type="checkbox"/> |
| Injury/illness     | <input type="checkbox"/> | Unfit         | <input type="checkbox"/> | Appearance | <input type="checkbox"/> |
| Lack of knowledge  | <input type="checkbox"/> | Family        | <input type="checkbox"/> | Work       | <input type="checkbox"/> |

## Diet and Nutrition

On a scale of 1-10 (**with 1 being poor and 10 being excellent**) how would you assess the quality of your eating habits?

Would you like any help or advice in changing the quality of your eating habits? **Yes / No**

## Do you follow any particular diet or eating patterns?

### Lifestyle

Do you drink alcohol? **Yes / No**

Do you smoke? **Yes / No**

If you answered 'Yes', would you like help or advice to change these habits? **Yes / No**

## Medical History

Have you had a major illness or injury in the last 5 years **Yes / No**

If 'Yes' please give details \_\_\_\_\_

Are you receiving treatment for any diagnosed medical condition? **Yes / No**

If 'Yes' please give details \_\_\_\_\_

Are you taking any prescription medication? **Yes / No**

If 'Yes' please give details \_\_\_\_\_

## Please indicate if you ever experience any of the following symptoms. Do you:

Ever get unusually short of breath with very light exertion?

Ever have pain, pressure, heaviness or tightness in the chest area?

Regularly have unexplained pain in the abdomen, shoulders or arm?

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**Please indicate if you ever experience any of the following symptoms. Do you:**

- Ever have severe dizzy spells or episodes of fainting?
- Regularly get lower leg pain during walking that is relieved by rest?
- Ever experience palpitations or irregular heartbeats?
- Are you currently pregnant or have you given birth in the last 6 months? **Yes / No**

## Structural Health

Please indicate on the figures below any aches, pains or problem areas.

Please give details of any areas indicated

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Are any of these injuries aggravated by exercise? **Yes / No**

Are you currently receiving treatment for any structural problem? **Yes / No**

Please indicate any other health problems you suffer from which you have not already mentioned.

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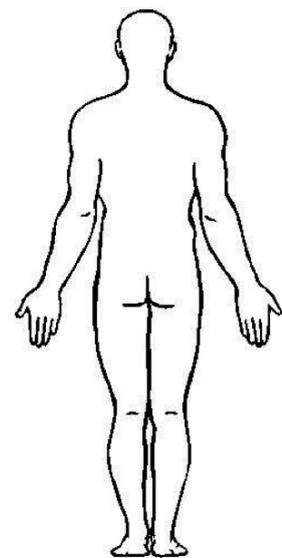
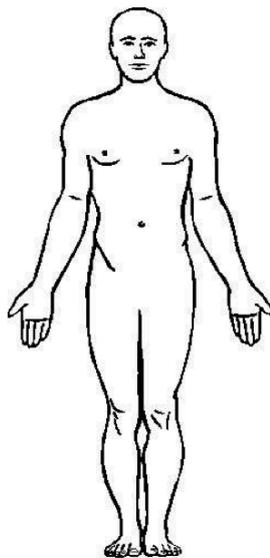
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I can confirm that I have answered all questions honestly and that the information given is correct.

Signature: \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** This PAR Q becomes invalid should your condition change.