2021 PAR-Q+

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 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 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1. Has your doctor ever said that you have a heart condition☐ **OR** high blood pressure☐?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
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).*	☐	☐
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** ____________	☐	☐
5. Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** ____________	☐	☐
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:** ____________	☐	☐
7. Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

◇ **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. <u>You do not need to complete Pages 2 and 3</u>.**

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (see the WHO Physical Activity Fact Sheet).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 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 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.

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		YES	NO
1.	**Do you have arthritis, osteoporosis, or back problems?** *If **YES**, answer questions 1a-1c. If **NO**, skip to question 2.*	YES ☐	NO ☐
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 have cancer of any kind?** *If **YES**, answer questions 2a-2b. If **NO**, skip to question 3.*	YES ☐	NO ☐
2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, 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, or diagnosed abnormality of heart rhythm). *If **YES**, answer questions 3a-3d. If **NO**, skip to question 4.*	YES ☐	NO ☐
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 heartbeat that required 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 refrained from regular physical activity for the last 2 months?	YES ☐	NO ☐
4.	**Do you have high blood pressure?** *If **YES**, answer questions 4a-4b. If **NO**, skip to question 5.*	YES ☐	NO ☐
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, or Pre-Diabetes. *If **YES**, answer questions 5a-5e. If **NO**, skip to question 6.*	YES ☐	NO ☐
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 ☐

Question	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, or down syndrome. *If **YES**, answer questions 6a-6b. If **NO**, skip to question 7.*	YES ☐	NO ☐
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 ALSO have back problems affecting nerves or muscles?	YES ☐	NO ☐
7. Do you have a respiratory disease? This includes Chronic Obstructive Pulmonary Disease, asthma, or pulmonary high blood pressure. *If **YES**, answer questions 7a-7d. If **NO**, skip to question 8.*	YES ☐	NO ☐
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, labored 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 **YES**, answer questions 8a-8c. If **NO**, skip to question 9.*	YES ☐	NO ☐
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 **YES**, answer questions 9a-9c. If **NO**, skip to question 10.*	YES ☐	NO ☐
9a. Do you have difficulty controlling you 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 **YES**, answer questions 10a-10c. If **NO**, read the Page 4 recommendations.*	YES ☐	NO ☐
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? **PLEASE LIST YOUR MEDICAL CONDITIONS:** ______ **LIST ANY RELEVANT MEDICATIONS:** ______	YES ☐	NO ☐

Go to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

◇ **If you answered NO to all of the follow-up questions 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, 3-5 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 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 eparmedx.com and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further

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- Your health changes – talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- 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.

NAME: ______________________________ **DATE:** ______________

Submit