Personal Training Assessment

NAME:____ DATE:________________

HEIGHT:_________in. WEIGHT:___________lbs. AGE:__________

EMAIL:____

PHYSICIANS NAME:___________________________ PHONE:_____________

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Questions: Yes / No

1 Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor? Y N

2 Do you feel pain in your chest when you perform physical activity? Y N

3 In the past month, have you had chest pain when you were not performing any physical activity? Y N

4 Do you lose your balance because of dizziness or do you ever lose consciousness? Y N

5 Do you have a bone or joint problem that could be made worse by a change in your physical activity? Y N

6 Is your doctor currently prescribing any medication for your blood pressure or for a heart condition? Y N

7 Do you know of any other reason why you should not engage in physical activity?
If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition. Y N

Occupation

What is your current occupation?

____

____

____

____

Repetitive Movements

Do you have any repetitive movements on a daily basis?

___

___

___

Sitting

Does your occupation require extended periods of sitting?

___

___

___

Hobbies

Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.)

___

___

___

Recreational Activities

Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.)

___

___

___

Family

Do you have a family? Do they support you in having a healthier lifestyle?

___

___

___

Injuries

Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.)

___

___

___

Surgeries

Have you ever had any surgeries? (If yes, please explain.)

Diseases

Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.)

Medications

Are you currently taking any medication? (If yes, please list.)

Goals

What are you goals? What is it specifically that you’d like to accomplish?