



PAR- Q

Participants

Name: _____ DOB: ____/____/____

Email Address: _____ Phone: _____

Health History:

1. Do you have a history of heart disease or have you ever experienced chest pain during physical activity?
 - ☐ Yes
 - ☐ No
2. Have you ever been diagnosed with high blood pressure?
 - ☐ Yes
 - ☐ No
3. Do you have any joint problems or musculoskeletal issues that may affect your ability to exercise safely?
 - ☐ Yes: please specify: _____
 - ☐ No
4. Have you had any recent surgeries or medical procedures that could impact your ability to exercise?
 - ☐ Yes: please specify: _____
 - ☐ No

Current Medications:

Please list any medications you are currently taking, including over-the-counter medications and supplements: _____

Physical Activity History:

1. Are you currently participating in any regular physical activity or exercise program?
 - ☐ Yes: please describe: _____
 - ☐ No
2. Have you ever had a fitness assessment or worked with a personal trainer before?
 - ☐ Yes: please provide details: _____
 - ☐ No

Lifestyle and Habits:

1. Do you smoke or use tobacco products?
 - ☐ Yes
 - ☐ No
2. Do you consume alcohol regularly?
 - ☐ Yes: please specify frequency: _____
 - ☐ No
3. Do you have any allergies or dietary restrictions that may affect your nutrition or exercise program?
 - ☐ Yes: please specify: _____
 - ☐ No

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Declaration:

I declare that the information provided in this PAR-Q form is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform my fitness trainer of any changes in my health or physical condition. I hereby release Dreams Driven Fitness LLC, their representatives, agents, successors, and the facility from any liability for injuries that may occur during or as a result of my participation in the fitness program.

Please print name (Parent/Guardian)

Signature

Date