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Class-Based Activity

Participants’ Data Collection Form and Physical Activity Readiness Questionnaire (PAR Q)

I need to collect and store some information about you to ensure that exercises are safe and effective. If you are between 21 and 69 years old, the questions will help me assess the state of your health to ensure you may participate in physical activity with me. If you are over 69 years old and do not participate in regular exercise, I will need confirmation from your GP that you may participate safely.

**You are not obliged to provide me with any data, and per the Data Privacy Notice, you may withdraw your consent for me to store or use your data at any time. However, the absence of data may limit or stop us from working together.**

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| Given Name(s) |  |
| Family Name |  |
| Date of birth |  |
| Address |  |
| E-mail Address(es) |  |
| Marketing Preferences: I will only ever use email to communicate marketing information. | May I contact you about services other than classes?  Yes/No  May I contact you with information about related services (provided by other businesses) that may interest you?  Yes/No |
| Your Health Goals | What is your main motivation for attending this class?  What goal do you want to achieve in the next 1 – 8 weeks in relation to your health?  What goal do you want to achieve in the next 9 - 24 weeks in relation to your health?  What goal do you want to achieve in the next 6 months in relation to your health?  What benefit will you get from achieving your goal? |
| Emergency Contact Details |  |

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| **Physical Activity Readiness Questionnaire PARQ+**  **Section 1** | |
| The health benefits of regular physical activity are clear and participating in physical activity is very safe for MOST people.  This questionnaire will tell you whether you must seek further advice from your doctor OR another qualified exercise professional before becoming more physically active. | |
| Please read the 7 questions below carefully and answer each one with a Yes or 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)? | If yes; PLEASE LIST CONDITION(S) HERE |
| 5) Are you currently taking prescribed medications for a chronic medical condition? | If yes; PLEASE LIST CONDITION(S) 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. | If yes; 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.  Please sign the PARTICIPANT DECLARATION at the end of this form - you **do not need** to complete section 2.  You should however delay taking part in an exercise session if:   * You are feeling unwell with a temporary illness such as a cold or flu, or you have had a stomach upset in the last 48 hours. * If you have given blood in the last 24 hours. * If you are, or think you may be, pregnant – please talk to your GP before becoming more physically active.   If your health changes – please complete these questions again and/or talk to your doctor before continuing with any physical activity program. | |
| If you answered YES to one or more of the questions above, please COMPLETE SECTION 2. | |

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| **Section 2**  **FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)** | |
| 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)  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)?  1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? |  |
| 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 4.  2a Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?  2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy). |  |
| Do you have a Heart or Cardiovascular Condition?  This includes Coronary Artery Disease, Heart Failure, and 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)  3b. Do you have an irregular heartbeat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)  3c. Do you have chronic heart failure?  3d. Do you have a diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? |  |
| Do you currently have High Blood Pressure?  If the above condition(s) is/are present, answer questions 4a-4b 4a. 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)  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). |  |
| 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 not go to question 6.  5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?  5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycaemia) following exercise and/or during activities of daily living? Signs of hypoglycaemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.  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?  5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?  5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise shortly? |  |
| Do you have any Mental Health Problems or Learning Difficulties?  This includes Alzheimer’s, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, and 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)  6b. Do you have Down Syndrome AND back problems affecting nerves or muscles? |  |
| 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).  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?  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?  7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? |  |
| 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).  8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?  8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? |  |
| 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 9.  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).  9b. Do you have any impairment in walking or mobility?  9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? |  |
| 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.  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?  10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?  10c. Do you currently live with two or more medical conditions? PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS. |  |

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| If you answered NO to all of the FOLLOW-UP questions (Section 2) about your medical condition, you are ready to become more physically active.  Please sign the PARTICIPANT DECLARATION below.  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 initially consult your GP for advice. | |
| When starting to exercise, 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.  All persons who have completed the PAR-Q+ please read and sign the declaration below. | |
| **PARTICIPANT DECLARATION**  I have read and understood this questionnaire to my full satisfaction and have completed it accurately.  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 acknowledge that the class leader will retain a copy of this form for records. In these instances, she will maintain the confidentiality of the same, complying with applicable law. | **Name/signature and Date** |