



Prescription of Exercise Consultation Form

PERSONAL DETAILS [FIELDS MARKED WITH (*) ARE COMPULSARY]

First name*:	Surname*:
Date of Birth*:	Gender:
Email*:	Tel:
Height:	Weight:

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q) [COMPLETE ALL FIELDS]

Yes No

Has your doctor ever said that you have a heart condition OR high blood pressure?

Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?

Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months?

Have you ever been diagnosed with another chronic medical condition?
- If so, what?

Are you currently taking any medication?
- If so, what?

Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, tendon) problem that could be made worse by becoming more physically active?
- If so, what?

Has your doctor ever said that you should only do medically supervised physical activity?

Do you have any other special considerations (e.g. pregnancy, pre-diabetes, asthma, epilepsy, COPD, cancer, osteoporosis, previous surgery etc)?
- If so, what?

Note: Answers given may not necessitate any change to guidance, though as a qualified exercise professional further advice may be required subsequently OR with your doctor before becoming more physically active.

DECLARATION

I agree that the information I have given is correct and to the best of my knowledge. I have sought and followed any necessary medical advice. I understand that all the information given will be kept confidential.

Signature: _____ Date: _____