

VOLKMAR PERFORMANCE, LLC
Medical & Health History Questionnaire



Name: _____ **Date:** ___ / ___ / ___ **Phone #:** (____) _____

DOB: ___ / ___ / ___ **Age:** _____

In Case of Emergency: Contact Person: _____ **Phone #:** (____) _____

For Office Use Only: Orientation Date: ___ / ___ / ___ **Administered by:** _____

Participant signature confirmation of orientation: _____

PAR-Q - Physical Activity Readiness Questionnaire

Please answer all questions accurately and honestly.

1. Has your doctor ever said you have heart trouble? YES NO
2. Do you frequently suffer from pains in your chest? YES NO
3. Do you often feel faint or have spells of severe dizziness? YES NO
4. Has your doctor ever said your blood pressure was too high? YES NO
5. Has your doctor ever told you that you have a bone or joint problem such as arthritis, which may be aggravated or made worse with exercise? YES NO
6. Is there a good physical reason not mentioned here why you should not follow an exercise program if you wanted to? YES NO
7. Are you over age 65 and unaccustomed to vigorous exercise? YES NO

If you have answered YES to ANY question, vigorous exercise or exercise testing should be postponed. Please contact your Primary Care Physician (PCP) to discuss your plan to begin an exercise program and which questions you answered YES. The VOLKMAR PERFORMANCE, LLC must have a signed note from you PCP before you begin an exercise program.

If you honestly answered NO to ALL questions, please continue. If your health changes to affect your answers to the above questions, please tell VOLKMAR PERFORMANCE, LLC immediately.

Participant Signature: _____ Date: ___ / ___ / ___

Parent Signature: _____ Date: ___ / ___ / ___

CARDIO-RESPIRATORY HISTORY:

Have you ever had the following?

- Y / N Irregular heart rhythm
- Y / N Skipped heart beats
- Y / N Asthma, Emphysema, or Bronchitis
- Y / N Allergies
- Y / N Chest Pain or tightness
- Y / N Dizziness or fainting
- Y / N High or low blood sugar
- Y / N Shortness of breath

Explain if you answered YES to any of the above:

*Do you have any other muscle, bone or joint problems?

- Yes
- No

Explain if you answered YES to any of the above:

MEDICAL & HEALTH HISTORY:

1. List any prescription or non-prescription medications or supplements that you take:

2. Are you aware of any other limitations that were not covered by this questionnaire which would restrict your participation in a planned exercise program?

I, the parent of _____, realize that participation in a Fitness Program involves certain inherent risks that regardless of the precautions taken by the VOLKMAR PERFORMANCE, LLC Staff or the participants, serious injuries may occur. **I UNDERSTAND THERE IS A RISK OF SERIOUS INJURY TO MY CHILD AS A RESULT OF THESE ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY.** I will be financially responsible for any medical attention needed as a result of injury. I confirm that my child has seen a licensed physician and is physically able to participate in physical fitness programs. I give permission for my child to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the named emergency contact person, before this action is taken.

Signature of Parent, Guardian, or Participant

Date

References:

1. American College of Sports Medicine (ACSM). *ACSM's Guidelines for Exercise Testing and Prescription*, 6th Edition, 2000. www.acsm.org

MUSCULOSKELETAL HISTORY:

Have you ever experienced injuries, surgeries, or precautions with the following?

- Y / N Neck
- Y / N Shoulder
- Y / N Back
- Y / N Elbow
- Y / N Wrist
- Y / N Hip
- Y / N Knee
- Y / N Ankle

Other: _____

Explain if you answered YES to any of the above:

*Do you experience any pain with exercising or strength training?

- Yes
- No

Explain if you answered YES to any of the above: