Par Q and Consent Form

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Emergency Contact and Par Q
(Physical Activity Readiness and Questionnaire)

Our client's health and safety are of the utmost importance and it is essential that we make sure it is physically safe for you to be working out with OVERTIME FITNESS INC. All information received on this form will be treated as strictly confidential. Please fill out the forms with thorough detail. This information is essential to helping our facility and staff provide the right delivery of services to your individual needs, goals and interests in a safe and effective manner.

Name: **Date of Birth (MM/DD/YYYY):**

Address: **Phone Number:**

Email Address: **Occupation:**

Postal Code: **How did you hear about us?:**

Emergency Contact Info: Parent or Guardian of Youth

First Name: **Last Name:**

Phone Number: **Email Address:**

PAR - Q FORM Please indicate **YES** or **NO** to the following:

	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?		
Do you have chest pains when you are not doing any physical activity?		
Do you frequently have pains in your chest when you perform physical activity?		
Do you lose your balance due to dizziness or do you ever lose consciousness?		
Do you have a bone, joint or any other health problem that causes you pain or limits you from certain exercise?		
Do you have any significant health problems such as: diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy,		

respiratory ailments, back problems, etc that would require modification to exercise programming?		
Are you pregnant now or have given birth within the last 6 months?		
Have you had a recent surgery?		
Do you take any medications, either prescription or non-prescription, on a regular basis? What is the medication for?		
Does this medication affect your ability to exercise or achieve your fitness goals?		
How would you rate your current fitness level **(1-10): _____**		

If you selected "YES" to any of the above. You will need to fill out questions on the following pages.

If you selected "NO" to all of the above please go down to the bottom and sign the document.

1. Do you have Arthritis, Osteoporosis, or Back Problems? YES/NO (No go to next question)

	YES	NO
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		
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). Details:		
Have you had steroid injections or taken steroid tablets regularly for more than 3 months?		

2. Do you currently have Cancer of any kind? YES/NO (No go to next question)

	YES	NO
Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head and or neck? Details:		
Are you currently receiving cancer therapy (such as chemo or radiotherapy)		

3. Do you have a heart or Cardiovascular Condition? YES/NO (No go to next question)
   This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

	YES	NO
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		
Do you have an irregular heartbeat that requires medical management?		
Do you have chronic heart failure?		
Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?		

4. Do you currently have High Blood Pressure? YES/NO (No go to next question)

	YES	NO
Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?		
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 chronic heart failure?		
Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?		

5. Do you have Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes YES/NO (No go to next question)

	YES	NO
Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?		
Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?		
Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.		
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?		
Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?		
Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?		

6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, intellectual Disability, Down Syndrome
YES/NO (No go to next question)

	YES	NO
Do you have Down Syndrome AND back problems affecting nerves or muscle?		

7. Do you have a respiratory disease?
   This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure YES/NO (No go to next question)

	YES	NO
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)		
Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?		
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?		
Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?		

8. Do you have a Spinal Cord Injury?
   This includes Tetraplegia and Paraplegia
   YES/NO (No go to next question)

	YES	NO
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)		
Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?		
Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?		

9. Have you had a Stroke?
   This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event
   YES/NO (No go to next question)

	YES	NO
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)		
Do you have any impairment in walking or mobility?		
Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?		

10. Do you have any other medical condition not listed above or do you have two or more medical conditions? YES/NO (No go to next question)

	YES	NO
Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months?		
Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?		
Do you currently live with two or more medical conditions?		

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE:

_____

_____

IF YOU ANSWERED NO TO ALL OF THE FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION, AND YOU ARE READY TO BECOME MORE PHYSICALLY ACTIVE - 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 physically active.

_____

PARTICIPANT DECLARATION

All persons who have completed the PAR-Q+ please read and sign the declaration below.

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. 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 also acknowledge that the community/fitness centre may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name_____ Date_____

Signature_____ Witness_____

Signature of Parent/Guardian/Care Provider_____