EVERGREEN PHYSICAL THERAPY

PAR-Q AND MEDICAL HISTORY

NAME: _____ **DOB**: _____

AGE: _____ ***HEIGHT:** _____ ***WEIGHT:** _____

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below and answer each one honestly: Check YES or NO	**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? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise)		
Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? Please list condition(s) here: _____		
Are you currently taking prescribed medication for a chronic medical condition? Please list medication and condition below.		
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? Please answer No if you had a problem in the past, but it does not limit your current ability to be physically active. Current Condition: _____		
Has your doctors ever said that you should only do medically supervised physical activity?		

*** LIST OF CURRENT MEDICATIONS AND DOSAGE** ***CONDITION**

_____ _____

_____ _____

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

If you have answered NO to all of the questions above, you are cleared for physical activity. Please sign the Participation Declaration.
If you have answered "YES" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

PARTICIPANT DECLARATION
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 center may retain a copy of this form for its 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 _____

MEDICAL HISTORY

***ARE YOU CURRENTLY EXPERIENCING ANY TYPE OF PAIN, DISCOMFORT, or CONCERN?** ☐ YES ☐ NO

PLEASE EXPLAIN or DESCRIBE:

_____

_____

_____

***Please rate the concern/pain in the last 24 hours: DURING ACTIVITY _____ DURING REST _____**
(Scale of 1-10; 10 severe/highly concerning; 1 Very Mild/Of little concern)

How often do you experience your symptoms:

- ☐ Constantly (76-100% of Day)
- ☐ Frequently (51-75% of Day)
- ☐ Occasionally (26-50% of Day)
- ☐ Intermittently (0-25% of Day)

What makes the pain/concern better? _____

What makes the pain/concern worse? _____

HAVE YOU RECENTLY NOTED:

- ☐ Weight Loss/Gain
- ☐ Nausea/Vomiting
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/Chills/Sweats
- ☐ Numbness/Tingling
- ☐ Pregnant/IUD
- ☐ Headaches
- ☐ Change in Vision/ Hearing
- ☐ Pain at Night
- ☐ Leg Cramps when Walking
- ☐ Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Surgeries
- ☐ Loss of Consciousness
- ☐ Fractures
- ☐ Sprains/ Strains
- ☐ Diabetes
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Cancer
- ☐ Arthritis
- ☐ Circulation / Clots
- ☐ Asthma / Breathing Problems
- ☐ Lung Disease
- ☐ Fainting
- ☐ Easy Brulsing/Bleeding
- ☐ Leg / Ankle Swelling
- ☐ Difficulty Swallowing
- ☐ Osteoporosis
- ☐ Urinary Problems/Infections
- ☐ Anxiety/Stress Disorders
- ☐ Alzheimer's/Dementia
- ☐ Eating Disorder
- ☐ Intellectual Disability
- ☐ Stroke
- ☐ Spinal Cord Injury
- ☐ Other: _____

***Have you had 2 or more FALLS within the last 12 months?** ☐ YES ☐ NO

***Have you had at least one FALL WITH AN INJURY in the last 12 months?** ☐ YES ☐ NO

***TYPE OF ALLERGIES (IF ANY) :** _____

***Please list all vitamins and dietary supplementation, including dosage and/or frequency:**

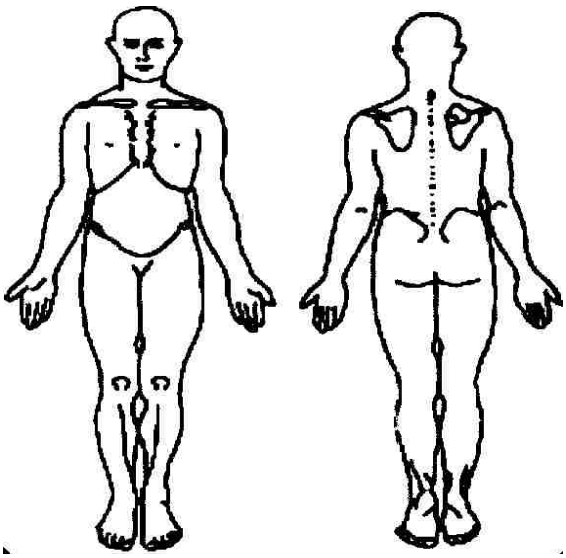
_____

_____

_____

PAST OR CURRENT INJURIES/CONCERNS

PLEASE INDICATE ALL LOCATIONS:



EXPLAIN AND GIVE APPROXIMATE DATES FOR ANY ITEMS INDICATED ABOVE: _____

_____

_____

_____

IS THERE ANYTHING ELSE YOU'D LIKE TO ADDRESS WHILE AT THE PT LAB? (EX: WEIGHT LOSS, CHRONIC PAIN, IMPROVE BALANCE, ETC):

_____

_____

_____

I have listed all my known medical conditions and physical limitations to the best of my knowledge. I will inform in writing of any change in my physical health between sessions. I understand that an Evergreen PT Staff Member must be aware of all existing physical conditions that I have in order to provide appropriate modalities. I further understand that a personal trainer neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have. In consideration of this, I, for myself, my heirs, and my legal representatives, do hereby release and forever discharge Evergreen Physical Therapy and PT Lab and its officers and employees from any and all causes of actions, suits, debts, claims and demands of any whatsoever arising from or by reasons of any injuries which might occur as a result of having participated in a personal training or group exercise class. I have read the above information. I understand this policy and agree to its terms.

X_____ _____

MEMBER OR AUTHORIZED SIGNATURE **DATE**

X_____ _____

EVERGREEN PT LAB STAFF REVIEWER **DATE**