


2017 PAR-Q+






The Physical Activity Readiness Questionnaire for Everyone

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 exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS




Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
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. PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

 **If you answered NO to all of the questions above, you are cleared for physical activity. Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

-  Start becoming much more physically active – start slowly and build up gradually.
-  Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
-  You may take part in a health and fitness appraisal.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
-  If you have any further questions, contact a qualified exercise professional.

 **If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.**

 **Delay becoming more active if:**

-  You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
-  You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
-  Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.



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01-01-2017

1 / 4

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2017 PAR-Q+

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 <input type="checkbox"/> 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) YES <input type="checkbox"/> NO <input type="checkbox"/>
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)? YES <input type="checkbox"/> NO <input type="checkbox"/>
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
<hr/>	
2. Do you currently have Cancer of any kind?	
If the above condition(s) is/are present, answer questions 2a-2b If NO <input type="checkbox"/> go to question 3	
2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? YES <input type="checkbox"/> NO <input type="checkbox"/>
2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES <input type="checkbox"/> NO <input type="checkbox"/>
<hr/>	
3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm	
If the above condition(s) is/are present, answer questions 3a-3d If NO <input type="checkbox"/> 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) YES <input type="checkbox"/> NO <input type="checkbox"/>
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES <input type="checkbox"/> NO <input type="checkbox"/>
3c.	Do you have chronic heart failure? YES <input type="checkbox"/> NO <input type="checkbox"/>
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
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4. Do you have High Blood Pressure?	
If the above condition(s) is/are present, answer questions 4a-4b If NO <input type="checkbox"/> 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) YES <input type="checkbox"/> NO <input type="checkbox"/>
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) YES <input type="checkbox"/> NO <input type="checkbox"/>
<hr/>	
5. 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 NO <input type="checkbox"/> go to question 6	
5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES <input type="checkbox"/> NO <input type="checkbox"/>
5b.	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. YES <input type="checkbox"/> NO <input type="checkbox"/>
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? YES <input type="checkbox"/> NO <input type="checkbox"/>
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? YES <input type="checkbox"/> NO <input type="checkbox"/>
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES <input type="checkbox"/> NO <input type="checkbox"/>



2017 PAR-Q+

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*
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) YES ☐ NO ☐

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐

7. 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) YES ☐ NO ☐

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? YES ☐ NO ☐

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? YES ☐ NO ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐

8. 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) YES ☐ NO ☐

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐

9. 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 10

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) YES ☐ NO ☐

9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐

10. 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 If **NO** ☐ read the Page 4 recommendations

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? YES ☐ NO ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐

10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

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

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.



2017 PAR-Q+



If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- 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.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.



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 complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at www.eparmedx.com and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.



Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

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 a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

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Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). *Health & Fitness Journal of Canada* 4(2):23-23, 2011.

Key References

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The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.



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4 / 4

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