

Physical Activity Readiness Questionnaire

Please read the questions below carefully and answer each one honestly, ticking the appropriate box (or filling the form in on-line and sending it back) plus adding any other information if necessary. Your responses will of course be kept in the strictest confidence. Many thanks!

Name:	Postcode:
Contact Tel no:	Email:
Has your doctor ever said that you have had a heart problem?	
No <input type="checkbox"/> Yes <input type="checkbox"/>	
In the past month have you had any chest pains when:	
You were doing any activity	No <input type="checkbox"/> Yes <input type="checkbox"/>
You were resting	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any further comments:	
Are you currently taking medication for:	
A heart condition	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any other problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any further comments:	
Do you suffer from any bone or joint problems?	
No <input type="checkbox"/> Yes <input type="checkbox"/>	
Any further comments:	
In the past year have you had any major illness or major surgery?	
No <input type="checkbox"/> Yes <input type="checkbox"/>	
Any further comments:	
Have you ever been diagnosed with the following:	
Diabetes No <input type="checkbox"/> Yes <input type="checkbox"/>	Asthma No <input type="checkbox"/> Yes <input type="checkbox"/>
Epilepsy No <input type="checkbox"/> Yes <input type="checkbox"/>	Other problems No <input type="checkbox"/> Yes <input type="checkbox"/>
Any further comments:	
Are you pregnant?	Have you recently had a baby?
No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/> How long ago?
Do you ever:	
lose your balance because of dizziness or lose consciousness No <input type="checkbox"/> Yes <input type="checkbox"/>	
Any further comments:	
Are you feeling unwell at present due to a bad cold, chest infection or flu, etc...	
No <input type="checkbox"/> Yes <input type="checkbox"/>	
Any further comments:	

If you have answered **YES** to one or more questions we may need you to contact your doctor before starting to exercise. If your health changes so that you may then answer **YES** to any of these questions, please contact **Mel or Neal Thomas** as soon as possible.

I have read, understood and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Signature: _____ Date: _____

Signature of Parent/Guardian (if aged 16 – 17) _____