**
Pre-Exercise Participation Questionnaire**

1. **Do you have any of the following symptoms?**

**If yes, you will need medical clearance from your doctor.**

* + Chest discomfort with exertion
	+ Unreasonable breathlessness
	+ Dizziness, fainting, or blackouts
	+ Ankle swelling
	+ Unpleasant awareness of a forceful, rapid or irregular heart rate
	+ Burning or cramping sensations in your legs when you walk short distances
	+ **None of the above**

**1.b If yes to any of the above fill in #2**

1. **Provider Information (Only if answered yes to #1)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you participate in regular physical activity? (Planned, structured physical activity for at least 30 minutes at a moderate intensity on at least 3 days a week for the last 3 months)**
* **Yes**
* No
1. **Have you had surgery in the past 12 months?**
	* **Yes**
	* No

**4.b If yes, what was the surgery and when?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

**Employee Initials:** \_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you currently have any of the following diagnoses within the last year? If yes, we recommend you contact your doctor to discuss the exercise activity level appropriate for you.**
	* Heart attack
	* Heart surgery, cardiac catheterization, or coronary angioplasty
	* Pacemaker/implantable cardiac defibrillator/rhythm disturbance
	* Heart valve disease
	* Heart failure
	* Heart transplantation
	* Congenital heart disease
	* Stroke/Transient Ischemic Attack (TIA)
	* Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
	* **None of the above**
2. **Have you had any diagnosed bone or joint injuries or diseases within the last 6 months?**
	* **If yes, list location(s) on your body:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	* No
3. **Are you currently or have you recently worked with a physical therapist?**
	* **If yes, complete the following:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* + No

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_