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