



The Register of
Exercise Professionals
PART OF THE SKILLSACTIVE GROUP

Physical Activity Readiness Questionnaire (PAR Q) Long version

Your Personal Details

Client Name: _____ DoB: _____
Address: _____
_____ Postcode: _____
Email: _____ Phone: _____

Emergency Contact Details

Name: _____
Address: _____
_____ Postcode: _____
Email: _____ Phone: _____

Your Health Goals

1. What health goals would you like to achieve in the next 3 months?

2. Name 3 things you could do in order to improve your health?

What are your main reasons for starting a fitness programme?

General conditioning	<input type="checkbox"/>	Muscular strength	<input type="checkbox"/>	No time	<input type="checkbox"/>
Weight /fat loss	<input type="checkbox"/>	Aerobic fitness	<input type="checkbox"/>	Appearance	<input type="checkbox"/>
Stress management	<input type="checkbox"/>	Flexibility	<input type="checkbox"/>	Improve self-esteem	<input type="checkbox"/>
Other	<input type="checkbox"/>				

How would you describe your general health and fitness?

Have you ever done any structured exercise?

Yes / No

If 'Yes' what did you do? _____

What type of exercise do you enjoy the most? _____

What type of exercise do you dislike the most? _____



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What would you say are the main barriers preventing you from exercising?

- | | | | | | |
|--------------------|--------------------------|---------------|--------------------------|------------|--------------------------|
| Lack of facilities | <input type="checkbox"/> | No motivation | <input type="checkbox"/> | No time | <input type="checkbox"/> |
| Injury/illness | <input type="checkbox"/> | Unfit | <input type="checkbox"/> | Appearance | <input type="checkbox"/> |
| Lack of knowledge | <input type="checkbox"/> | Family | <input type="checkbox"/> | Work | <input type="checkbox"/> |

Diet and Nutrition

On a scale of 1-10 (**with 1 being poor and 10 being excellent**) how would you assess the quality of your eating habits?

Would you like any help or advice in changing the quality of your eating habits? **Yes / No**

Do you follow any particular diet or eating patterns?

Lifestyle

Do you drink alcohol? **Yes / No**

Do you smoke? **Yes / No**

If you answered 'Yes', would you like help or advice to change these habits? **Yes / No**

Medical History

Have you had a major illness or injury in the last 5 years **Yes / No**

If 'Yes' please give details _____

Are you receiving treatment for any diagnosed medical condition? **Yes / No**

If 'Yes' please give details _____

Are you taking any prescription medication? **Yes / No**

If 'Yes' please give details _____

Please indicate if you ever experience any of the following symptoms. Do you:

Ever get unusually short of breath with very light exertion?

Ever have pain, pressure, heaviness or tightness in the chest area?

Regularly have unexplained pain in the abdomen, shoulders or arm?



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Please indicate if you ever experience any of the following symptoms. Do you:

- Ever have severe dizzy spells or episodes of fainting?
- Regularly get lower leg pain during walking that is relieved by rest?
- Ever experience palpitations or irregular heartbeats?
- Are you currently pregnant or have you given birth in the last 6 months? **Yes / No**

Structural Health

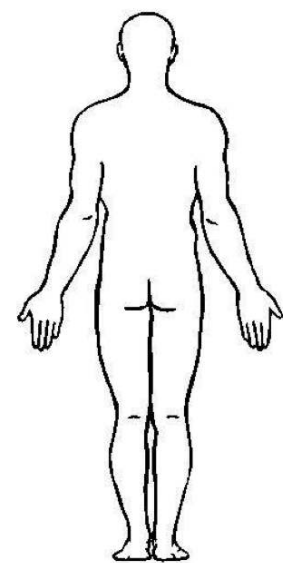
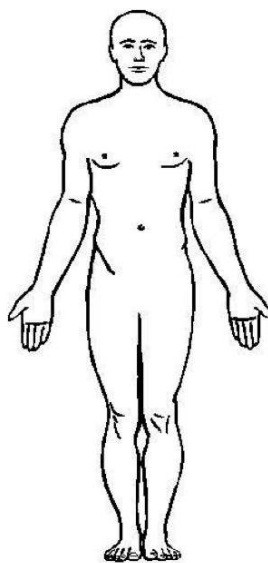
Please indicate on the figures below any aches, pains or problem areas.

Please give details of any areas indicated

Are any of these injuries aggravated by exercise? **Yes / No**

Are you currently receiving treatment for any structural problem? **Yes / No**

Please indicate any other health problems you suffer from which you have not already mentioned.



I can confirm that I have answered all questions honestly and that the information given is correct.

Signature: _____ Print name: _____ Date: _____