# Destiny Management

## **PAR-Q** (Physical Activity Readiness Questionnaire)

Today's Date:_____

For most people, physical activity should not pose any problem or hazard. This questionnaire has been designed to identify those people for whom physical activity might be inappropriate, or those who should have medical advice concerning the type of activity most suitable for them. If you answer "yes" to any of the questions below, consult with your doctor before starting any exercise program.

Name_____Sex: ☐M ☐F
Mailing Address_____
City_____State_____Zip Code_____-_____
Home Phone (_____)_____ Business Phone (_____)_____
E-mail address_____ Birthdate_____ Age_____
Employer's Name_____
Height_____ft _____in Weight _____lbs. Date of Last Physical Exam_____
Personal Physician_____ Phone_____
**Goals:**_____
_____
_____
_____
**Limitations:**_____
_____
_____
How many days per week can you commit to a resistance program?_____
How may days per week can you commit to a cardiovascular program?_____
What is the total amount of time per day you can commit to an exercise program?_____
How can we best assist you with a nutrition program?_____
How did you hear of Destiny Management?_____

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## General History

| | YES | NO |
|---|---|---|
| Do you currently have an illness or infection? Please specify:_____ | ☐ | ☐ |
| Has your physician ever told you that: | | |
| your cholesterol was too high? | ☐ | ☐ |
| your triglycerides were too high? | ☐ | ☐ |
| Do you have history of high blood pressure? | ☐ | ☐ |
| Have you been diagnosed with diabetes? | ☐ | ☐ |
| If yes: Are you taking medication? | | |
| ☐ Oral ☐ Injection | ☐ | ☐ |
| What kind of diabetes? ☐ Type I ☐ Type II | ☐ | ☐ |

## General History, cont.

**YES / NO**

Do you have a history of the following conditions?

| | | |
|---|---|---|
| Allergies | ☐ | ☐ |
| Infectious mononucleosis | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Multiple sclerosis | ☐ | ☐ |
| Epilepsy or other seizures | ☐ | ☐ |
| Liver disorder | ☐ | ☐ |
| Gallbladder problems | ☐ | ☐ |
| HIV positive | ☐ | ☐ |
| Renal disorder | ☐ | ☐ |
| Thyroid disorder | ☐ | ☐ |
| Other: Specify_____ | | |

| Family History (Immediate family only) | No | Yes | If yes: Age >50 | If yes: Age <50 |
|---|---|---|---|---|
| **Heart Attacks** | | | | |
| **High Blood Pressure** | | | | |
| **High Cholesterol** | | | | |
| **Stroke** | | | | |
| **Angina (Chest Pain)** | | | | |
| **Diabetes** | | | | |
| **Congenital Heart Disease** | | | | |
| **Aneurysms** | | | | |
| **Heart Operations** | | | | |
| **Asthma/Hay Fever** | | | | |
| **Obesity** | | | | |
| **Osteoporosis** | | | | |
| **Cancer** | | | | |

## Smoking History

**YES / NO**

☐ ☐

Do you currently smoke?
If so, for how many years?_____
Number of cigarettes, cigars and/or pipe bowls (circle one) smoked per day?_____
If you are an ex-smoker, when did you stop?_____

## Pulmonary History

YES / NO

Do you experience breathlessness after mild exercise? ☐ ☐

Have you ever experienced any of the following: ☐ ☐

Asthma? When_____
Bronchitis? When_____
Emphysema? When_____
Pneumonia? When_____
Lung Disease? When_____
Other? Specify_____

## Medications

YES / NO

Are you currently taking any medications? ☐ ☐

| **Medication** | **Condition** |
|---|---|
| | |
| | |
| | |
| **Over the Counter Supplements** | **Condition** |
| | |
| | |
| | |

## Nutritional History

Average number of caffeine drinks per day_____
Average number of alcoholic drinks per day_____
Are you presently dieting? ☐ yes ☐ no
If yes, what kind of diet? _____
Have you participated in structured diet plans in the past? ☐ yes ☐ no

If yes, please list:

| Name of Diet | Dates | Weight Lost | How Long Maintained Weight Loss? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Nutritional History, cont.

What was your heaviest weight? _____lbs.
What was your weight one year ago? _____lbs. At age 21 _____lbs.
What do you consider a healthy weight for yourself? _____lbs.
How would you describe your nutritional habits? (circle one)

excellent good fair poor

Have you ever had an eating disorder? ☐ yes ☐ no
If yes, what and when? _____
_____
How many meals do you eat per day? _____
What foods do you usually snack on? _____
_____

## Orthopedic History

Describe any present or past musculoskeletal or joint conditions you have (i.e muscle pulls, sprains, fractures, surgery, pain, arthritis, or any other general discomfort):

| When: | When: |
|---|---|
| head/neck | shoulder/clavicle |
| arm/elbow | wrist/hand |
| back | hip/pelvis |
| thigh/knee | lower leg/ankle/foot |

Do you have chronic, or recurrent pain in any part of your body? ☐ yes ☐ no
If yes, describe _____
What relieves the pain? _____
Do you avoid activity because of the pain? ☐ yes ☐ no
Do you have weakness in any particular part of the body? _____yes _____no
If yes, where? _____
Have you ever been diagnosed with osteoporosis? ☐ yes ☐ no
Are you currently undergoing physical therapy? ☐ yes ☐ no

## Women's Health

(circle one)
Are you currently pregnant? ☐/☐

Have you given birth in the last eight weeks? ☐/☐
Are you currently taking birth control pills? ☐/☐
Are you currently breast feeding? ☐/☐

## Cardiovascular History

**YES / NO**

Have you ever had any of the following:

| | YES | NO |
|---|---|---|
| Heart attack or stroke | ☐ | ☐ |
| Cardiac or vascular surgery or congestive heart failure | ☐ | ☐ |
| Cardiomyopathy (heart enlargement) | ☐ | ☐ |
| Abnormal resting or exercise EKG | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Phlebitis | ☐ | ☐ |

Do you have a history of any of the following:

| | YES | NO |
|---|---|---|
| Angina (chest pain) | ☐ | ☐ |
| Palpitations or tachycardia | ☐ | ☐ |
| Badly swollen feet or ankles | ☐ | ☐ |
| Severe dizziness or fainting | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Claudication (pain in the legs) | ☐ | ☐ |

## Lifestyle

Is your occupation:

☐ Sedentary
☐ Moderately active
☐ Active
☐ Heavy labor

How stressful is your occupation?

☐ Minimal
☐ Moderate
☐ Average
☐ Extreme

How would you characterize your overall stress level?

☐ high ☐ medium ☐ low

Average number of hours you sleep per night? _____

| |
|---|
| **Emergency contact:** |
| **Phone:**<br><br>**Relationship:** |

I understand the nature and purpose of the Physical Activity Readiness Questionnaire and am aware that any strenuous physical activity involves risks. Accordingly, I release, discharge, absolve, and hold harmless Destiny Management, their agents, instructors and employees, for any and all liability arising from any accident, injury, or loss sustained by me as a result of activities at or present in the Facility. I declare to the best of my knowledge my answers are true, correct, and complete.

_____
Signature

_____
Guardian Signature (if under 18 years of age)

_____
Date

_____
Reviewed by

**INFORMED CONSENT FOR A HEALTH RELATED EXERCISE TEST**

1. Explanation of the Exercise Test

   You will perform a battery of fitness tests that may include a cardiovascular test on a cycle ergometer or a bench step test, a sit & reach test for flexibility, a push-up test and a sit-up test for muscular endurance, and a body compositions test which is analyzed by taking several skinfold measures to calculate percentage of body fat along with circumference measurements. For the cardiovascular test, the exercise intensity will begin at a level you can easily maintain and will be advanced in stages depending on your fitness level. For the other tests, you will be going to failure. We may stop the tests at any time because of signs of fatigue or you may stop when you wish because of personal feelings of fatigue or discomfort.

2. Risks and Discomforts

   There exists the possibility of certain changes occurring during the tests. They include abnormal blood pressure, fainting, disorder of heart beat, and, in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during the tests. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

3. Responsibilities of the Participant

   Information you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your exercise tests. Your prompt reporting of feelings with effort during the exercise tests itself are also of great importance. You are responsible to fully disclose such information when requested by the testing staff.

4. Benefits to be Expected

   The results obtained from the exercise tests may assist in diagnosis of your illness or in evaluating what type of physical activities you might do with low risk of harm.

5. Inquiries

   Any questions about the procedures used in the exercise tests or in the estimation of functional capacity are encouraged. If you have any doubts or questions, please ask us for further explanations.

7. Freedom of Consent

   Your permission to perform these exercise tests are voluntary. You are free to deny consent or stop the test at any point, if you so desire.

I have read this form and I understand the test procedures that I will perform. I consent to participate in the tests.

Date: _____ Signature of Client: _____

***FOR OFFICE USE ONLY***

**Comments/Referrals:**

***FOR OFFICE USE ONLY***

**Comments/Referrals:**