CurveLab Fitness LLC

New Client Questionnaire

Name: ______________________ **Date:** ______________________

Lifestyle

1. How many hours a day do you sleep at night? __________
2. How often do you travel? ☐ Rarely ☐ A few times a year ☐ A few times a month ☐ Weekly
3. What would you rate your stress level from 1 to 10 (1= very low, 10= very high)? _____

Occupational

4. What is your current occupation? ______________________
5. Which most accurately describes your job? ☐ Sedentary ☐ Active ☐ Physically demanding
6. Does your job require extended periods of sitting? ☐ Yes ☐ No
7. Does your job require extended periods of standing? ☐ Yes ☐ No
8. Does your job require walking, running, climbing, or crawling? ☐ Yes ☐ No
9. Does your job require repetitive movements? ☐ Yes ☐ No

Fitness Goals

10. What would you rate your fitness level from 1 to 10 (1= very low, 10= very high) ? _____
11. How often do you exercise? ______________________
12. If your participation is lower that what you would like it to be, what are the reasons?

☐ Illness/Injury ☐ Lack of results ☐ Plateau ☐ Money ☐ Feeling self-conscious ☐ Lack of interest

____

What Results Would you Like?

- ☐ Reduce body fat
- ☐ Stress management
- ☐ Increase muscle size
- ☐ Tone
- ☐ Improve flexibility
- ☐ Rehabilitate an injury
- ☐ Other: __________
- ☐ Sports conditioning
- ☐ Strength training
- ☐ Increase stamina
- ☐ Weight loss
- ☐ A certain look
- ☐ Motivation
- ☐ Recomposition

Where?

- ☐ Stomach
- ☐ Legs
- ☐ Glutes
- ☐ Arms
- ☐ Back
- ☐ Shoulders
- ☐ Other: __________
- ☐ Hips
- ☐ Waist
- ☐ Chest

13. What are your fitness goals? ______________________

____

____

14. When do you hope to achieve these results? ______________

15. How do you prefer to exercise? ☐ Alone ☐ In a group ☐ A combination

16. How many weeks do you wish to exercise? ______________

17. What time of the day do you prefer? ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

18. How often do you wish to see your trainer? ______________

19. **List the days that work best for you to commit to your training program:** ______________

Nutrition

21. What would you rate your nutrition from 1 to 10 (1 = very low, 10 = very high)? ______________

22. How many times a day do you usually eat (including snacks)? ______________

23. Do you skip meals? ☐ Yes ☐ No

24. Do you eat late at night? ☐ Yes ☐ No

25. Are you currently taking multivitamins or any other supplements? ☐ Yes ☐ No ______________

26. How many times per week do you eat out? ______________

27. Do you do your own grocery shopping? ☐ Yes ☐ No

28. Do you do your own cooking? ☐ Yes ☐ No

29. **Besides hunger, what other reason(s) do you eat:**

☐ Boredom ☐ Stressed ☐ Social ☐ Depressed ☐ Happy

30. **Do you follow a diet?**

☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Dairy-free ☐ Paleo ☐ Keto ☐ Low-carb Other: ______________

31. Do you have any food or non-food allergies? ______________

32. Anything else you would like to add regarding your fitness or nutrition? ______________

____

____

Body Composition Assessment

Body composition assessment

Name: ______________________ **Date:** ______________ **Time:** __________

Assessment #: ______ ______________________ **Gender:** __________

Height: ______________ **Weight:** ________ **BMI:** ______ **Body Fat %:** ________

Client Measurements

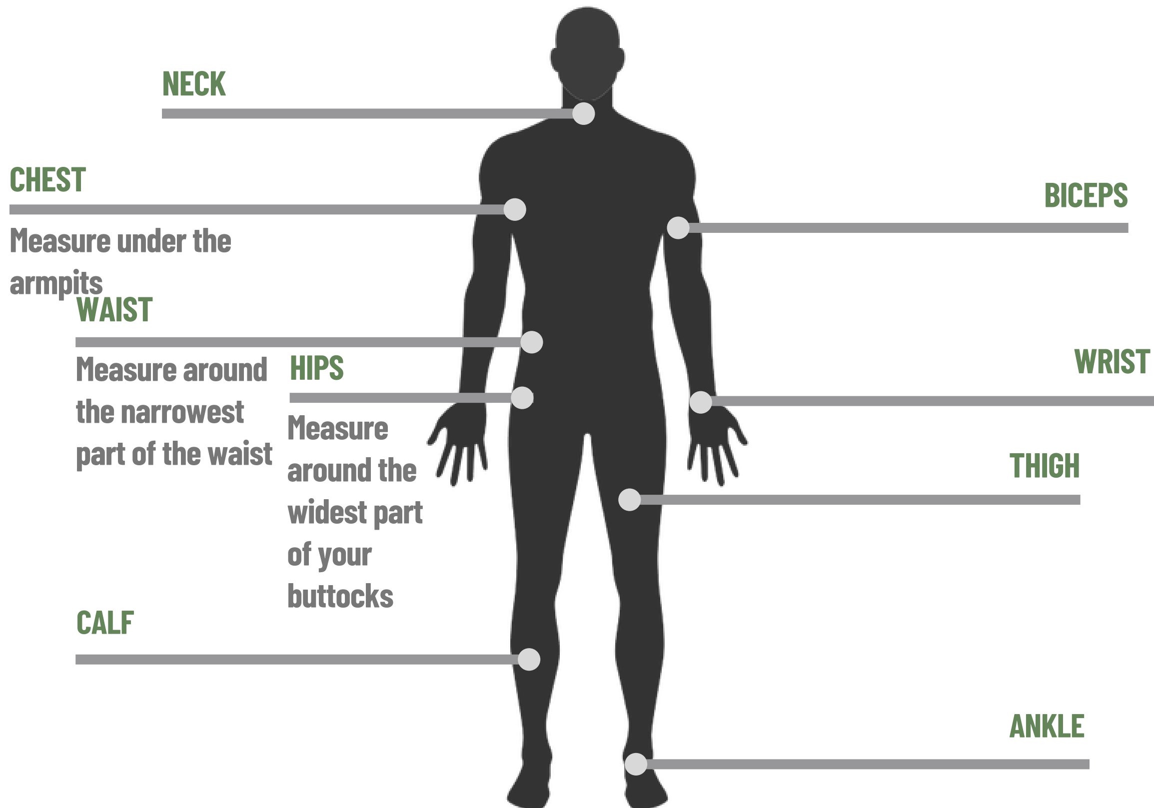
Neck: ______________ **Thigh:** __________ / ______________ in (Right/Left)

Chest: ______________ **Biceps:** __________ / ______________ in (Right/Left)

Waist: ______________ **Calf:** __________ / ______________ in (Right/Left)

Hips: ______________ **Wrist:** __________ / ______________ in (Right/Left)

Measurement Guide



Notes: ____

____

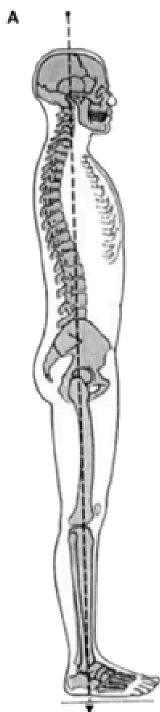
Postural Assessment

Postural observation of static posture

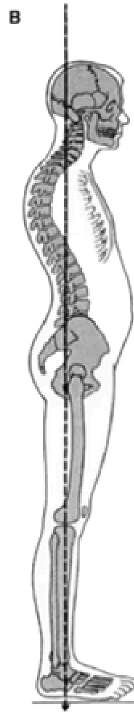
Name: ______________________ **Date:** ______________ **Time:** ____________

Assessment #: ________ **Height:** ______________ **Weight:** ____________ **BMI:** ____________

Postural Assessment Guide



IDEAL ALIGNMENT



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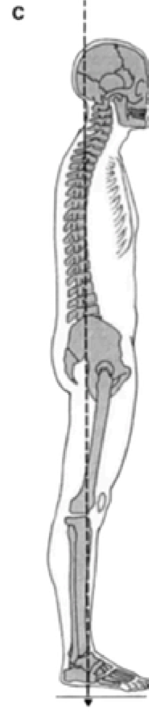
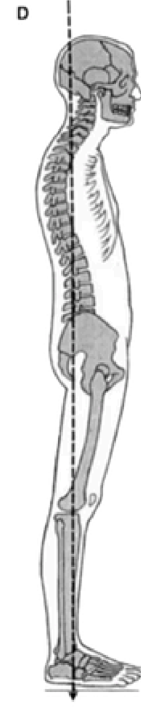


FLAT-BACK POSTURE



SWAY-BACK POSTURE

Postural Results

Postural assessment result: ______________________________

Notes: ______________________________

____

____

____

____

Health History Questionnaire

Medical information form

Name: ______________________ **Date of birth:** ____________ **Date:** ____________

Address: ____

City: ______________________ **State:** ____________ **Zip:** ____________

Phone(Cell): ____________ **(Work):** ____________ **Email address:** ____________

In case of emergency, whom may be contacted?

Name: ______________________ **Relationship:** ______________________

Phone (Cell): ______________________ **(Home):** ______________________

Health Care Provider: ____

Name: ______________________ **Phone:** ____________ **Fax:** ____________

Present/Past History

Have you had, or do you presently have any of the following? (Check if yes.)

- ☐ Heart attack
- ☐ Any kind of heart disease or heart surgery
- ☐ Diabetes
- ☐ Prediabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Kidney disease
- ☐ High Cholesterol
- ☐ Lung disease
- ☐ Seizures
- ☐ Cancer
- ☐ Rheumatic fever
- ☐ Recent operation
- ☐ Other (please describe): ____________

____

____

____

____

- ☐ Fainting or dizziness
- ☐ Chest pains
- ☐ Palpitations or tachycardia (unusually strong or rapid heartbeat)
- ☐ Known heart murmur
- ☐ Muscle or joint problems (e.g., back, knee)
- ☐ Edema (swelling of ankles)
- ☐ Pain, discomfort in the chest, neck, jaw, arms, or other areas
- ☐ Unusual fatigue or shortness of breath at rest or with light activity
- ☐ Temporary loss of clear vision or speech or short-term numbness or weakness in one side, arm, or leg of your body
- ☐ Shortness of breath while lying down, at night or that comes on suddenly
- ☐ Intermittent claudication (calf cramping)

Health History Questionnaire

Medical information form

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

☐ Heart attack
☐ Congenital heart disease
☐ High blood pressue
☐ High cholesterol
☐ Heart surgey
☐ Diabetes
☐ Other major illness: ______

Explain checked items: ______

Activity History

1. Why have you decided to seek exercise guidance at this time? ______
2. Were you referred to this program? ☐ Yes By whom: ______ ☐ No
3. Have you ever worked with a personal trainer before? ☐ Yes ☐ No
4. Date of your last physical examination performed by a physician: ______
5. Do you participate in a regular exercise program currently? ☐ Yes ☐ No

   If yes, briefly describe: ______
6. Can you currently walk 2 miles briskly without fatigue? ☐ Yes ☐ No
7. Have you ever performed strength training exercises in the past? ☐ Yes ☐ No
8. Do you have injuries (bone/muscle disabilities) that may interfere with exercising? ☐ Yes ☐ No

   If yes, briefly describe: ______
9. Do you smoke? ☐ Yes ☐ No ☐ Sometimes

   If yes, how much per day and what was your age when you started? ______
10. Do you drink alcohol? ☐ Yes ☐ No ☐ Sometimes

    If yes or sometimes, how much per week? ______
11. What is your body weight now? ______

    What was it one year ago? ______

    What was it at age 21? ______
12. Are you taking any medications currently?

    ☐ Yes ☐ No If yes, list below:

    ______

    ______
12. How tall are you? ______

Informed Consent Form

Consent and release for personal fitness training

Name: ______________________________ **Date:** ______________________________

1. Purpose and Explanation of Procedure

I hereby consent to voluntarily engage in an acceptable plan of personal fitness training. I also give consent to be placed in personal fitness training program activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness. I will be given exact personal instructions regarding the amount and kind of exercise I should do. A professionally trained personal fitness trainer will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program. I have been informed that during my participation in the above described personal fitness training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the personal fitness training program personnel of my symptoms, should any develop. I understand that during the performance of exercise, a personal fitness trainer will periodically monitor my performance and, perhaps measure my pulse, blood pressure, or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise program when any of these findings so indicate that this should be done for my safety and benefit. I also understand that during the performance of my personal fitness training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

2. Risks

It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

3.Benefits to be Expected and Alternatives Available to Exercise

I understand that this program may or may not benefit my physical fitness or general health. (Continued)

3.Benefits to be Expected and Alternatives Available to Exercise (Continued)

I recognize that involvement in the personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-8 months.

4. Confidentiality and Use of Information

I have been informed that the information which is obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide facts which could lead to my identification. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

5. Inquiries and Freedom of Consent

I have been given an opportunity to ask questions as to the procedures.

I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.

Participant's Name: ____________________ **Date:** ____________________

Participant's Signature: ____________________ **Witness's Signature:** ____________________

2022 PAR-Q+ Form

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

General Health Questions

Please read the 7 questions below carefully & answer each one honestly: check YES or NO.

Question	Yes	No
1. Has your doctor ever said that you have a heart condition? **OR** high blood pressure?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** ____________	☐	☐
5. Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** ____________	☐	☐
6. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it does not limit your current ability to be physically active. **PLEASE LIST CONDITION(S) HERE:** ____________	☐	☐
7. Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Please sign the PARTICIPANT DECLARATION on the next page to complete the PAR-Q+ Form. You do not need to complete the rest of the PAR-Q+ Form.

2022 PAR-Q+ Form

The Physical Activity Readiness Questionnaire for Everyone

If you answered NO to all of the questions on the previous page, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION below to complete the PAR-Q+ Form. You do not need to complete the rest of the PAR-Q+. If you answered YES PLEASE CONTINUE.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Participant's Name: ______________________ **Date:** ____________

Participant's Signature: ______________ **Witness's signature:** ____________

*If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

***Signature of parent/guardian or caregiver:** ______________________

If you answered YES to one or more of the questions on the previous page, PLEASE CONTINUE: COMPLETE PART 2 ON THE NEXT 5 PAGES

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the following questions of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

Only complete if you answered YES to one or more of the questions in PART ONE

FOLLOW UP QUESTIONS: Only complete the below if you answered YES to one or more of the questions above. Skip If you answered NO to all of the questions.

	Yes	No
1. Do you have Arthritis, Osteoporosis, or Back Problems? **If the above condition(s) is/are present, answer questions 1a-1c**	☐	☐
1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? Answer **NO** if you are not currently taking medications or other treatments)	☐	☐

2022 PAR-Q+ Form - Part 2

The Physical Activity Readiness Questionnaire for Everyone

CONTINUED FOLLOW UP QUESTIONS: Only complete the below if you answered YES to one or more of the questions on the first PAR-Q+ page.

	Yes	No
1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	☐	☐
1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	☐	☐
2. Do you currently have Cancer of any kind? **If the above condition(s) is/are present, answer questions 2a-2b**	☐	☐
2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	☐	☐
2b. Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	☐	☐
3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm. **If the above condition(s) is/are present, answer questions 3a-3d**	☐	☐
3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	☐	☐
3c. Do you have chronic heart failure?	☐	☐
3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	☐	☐
4. Do you currently have High Blood Pressure? **If the above condition(s) is/are present, answer questions 4a-4b**	☐	☐
4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	☐	☐
5. Do you have any Metabolic Conditions? This includes Type 1 and 2 Diabetes & Pre-Diabetes **If the above condition(s) is/are present, answer questions 5a-5e**	☐	☐

CONTINUED FOLLOW UP QUESTIONS: Only complete the below if you answered YES to one or more of the questions on the first PAR-Q+ page.

Question	Yes	No
5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician prescribed therapies?	☐	☐
5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	☐	☐
5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	☐	☐
5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	☐	☐
5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	☐	☐
6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome.*	☐	☐
If the above condition(s) is/are present, answer questions 6a-6b	☐	☐
6a. Do you have difficulty controlling your condition with medications or other physician therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	☐	☐
7. Do you have a Respiratory Disease? (*This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure)* **If the above condition(s) is/are present, answer questions 7a-7d**	☐	☐
7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	☐	☐

CONTINUED FOLLOW UP QUESTIONS: Only complete the below if you answered YES to one or more of the questions on the first PAR-Q+ page.

Question	Yes	No
7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	☐	☐
7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	☐	☐
8. Do you have a Spinal Cord Injury? (*This includes Tetraplegia and Paraplegia)* **If the above condition(s) is/are present, answer questions 8a-8c**	☐	☐
8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	☐	☐
8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dyslexia)	☐	☐
9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event* **If the above condition(s) is/are present, answer questions 9a-9c**	☐	☐
9a. Do you have difficulty controlling your condition with medications or other physician therapies? (Answer **NO** if you are not currently taking medications or other treatments)	☐	☐
9b. Do you have any impairment in walking or mobility?	☐	☐
9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	☐	☐
10. Do you have any other medical condition not listed above or do you have two or more medical conditions? **If you have other medical conditions, answer questions 10a-10c**	☐	☐
10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	☐	☐
10b. Do you have a medical condition that is not listed (*such as epilepsy, neurological conditions, kidney problems*)?	☐	☐

10c. *On next page.*

CONTINUED FOLLOW UP QUESTIONS: Only complete the below if you answered YES to one or more of the questions on the first PAR-Q+ page.

	Yes	No
10c. Do you currently live with two or more medical conditions?	☐	☐

Please list your medical conditions and any medications here:

If you answered NO to all of the FOLLOW-UP questions for Part 2 about your medical condition, you are ready to become more active - sign the PARTICIPANT DECLARATION on the next page:

- **It is advised that you consult a qualified exercise professional to help you develop a safe and elective physical activity plan to meet your health needs.**
- **You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.**
- **As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.**
- **If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.**

If you answered YES to one or more of the follow-up questions about your medical condition: You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening & exercise recommendations program - the ePARmed-X+ at www.eparmedx.com and/or visit a qualified exercise professional to work through the ePARmed-X+ & for further info.

Delay becoming more physically active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire. NO changes are permitted. The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

2022 PAR-Q+ Form - Part 2

The Physical Activity Readiness Questionnaire for Everyone

If you answered NO to all of the FOLLOW-UP questions after completing Part 2 about your medical condition, you are ready to become more active - please sign the PARTICIPANT DECLARATION below to complete the form:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Participant's Name: ______________________ **Date:** ______________

Participant's Signature: ______________________ **Witness's signature:** ______________

*If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

***Signature of parent/guardian or caregiver:** ______________________

Only 1 signature is necessary for this forms completion. Page 7 or 2.

For more information, please contact:

www.eparmedx.com

Email: eparmedx@gmail.com

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through "nancial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key references:

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the e!ectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

Citation for PAR-Q+ Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.