HEALTH HISTORY

DATE: _____

PHYSICAL ACTIVITY READINESS – PAR-Q

Y N 1. Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by your doctor?

Y N 2. Do you feel pain in your chest when you do physical activity?

Y N 3. In the past month have you had chest pain when you were not doing physical activity?

Y N 4. Do you loose your balance because of dizziness or ever loose consciousness?

Y N 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? (Neck, back, shoulder, elbow, wrist, hip, knee, ankle)

Y N 6. Is your doctor currently prescribing medication for your blood pressure or heart condition?

Y N 7. Do you know any other reason why you should not do physical activity?

FAMILY HISTORY

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions?
In addition, please indicate which relative and at what age the condition occurred.

Y N 1. Heart attack
Y N 2. Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)
Y N 3. Congenital heart disease
Y N 4. High blood pressure
Y N 5. High cholesterol
Y N 6. Diabetes
Y N 7. Other (please describe):

HEALTH HISTORY QUESTIONNAIRE

Have you had or do you presently have any of the following?

Y N 1. Recent operation
Y N 2. Cancer
Y N 3. Diabetes (TYPE 1 / 2)
Y N 4. Thyroid disease
Y N 5. Anxiety / Depression
Y N 6. Dizziness or fainting
Y N 7. Arthritis
Y N 8. Fibromyalgia
Y N 9. Osteoporosis
Y N 10. Seizures
Y N 11.Rheumatic fever
Y N 12. Asthma or lung disease
Y N 13. High cholesterol
Y N 14. High or low blood pressure
Y N 15. Edema (swelling of ankles)
Y N 16. Heart attack or known heart disease
Y N 17. Unusual fatigue or shortness of breath with usual activities
Y N 18. Orthopnea (the need to sit up to breathe comfortably)
Y N 19. Paroxysmal (sudden, unexpected attack of shortness of breath)
Y N 20. Nocturnal dyspnea (shortness of breath at night)
Y N 21. Sleep apnea
Y N 22. Angina (chest pain, neck, jaw, arms, or other areas)
Y N 23. Palpitations or tachycardia (unusually strong or rapid beat)
Y N 24. Known heart murmur
Y N 25. Intermittent claudication (leg pain / cramping)
Y N 26. Temporary loss of visual acuity or speech or short-term numbness or weakness in one side of body
Y N 27. Smoke or used to smoke:
Y N 29. Other (please describe):

MOTOR VEHICLE ACCIDENT

DATE OF MVA: _____ (circle one)

Were you were the:	Driver / Passenger / Pedestrian
Were you:	Accelerating / Breaking
Were you moving:	Forward / Reversing / Stopped
What direction were you looking:	Forward / Rear-view mirror / Left side mirror / Right side mirror
Where was your car hit:	Front / Rear-end / Left side / Right side / Other:
What was the speed of your vehicle:	_____km

Were you at fault of the accident?	No	Yes:_____
Did you hit a vehicle/object?	No	Yes:_____
Were your arms on the steering wheel?	No	Yes:_____
Were you wearing your seatbelt properly?	No	Yes:_____
Appropriate headrest and seat positions?	No	Yes:_____
Did you anticipate impact?	No	Yes:_____
Did you hit the steering wheel?	No	Yes:_____
Did the airbag inflate?	No	Yes:_____
Were you concussed or unconscious?	No	Yes:_____
Did you receive ambulatory care?	No	Yes:_____
Were you hospitalized?	No	Yes:_____
Were X-rays or MRI performed?	No	Yes:_____
Have you been involved in previous MVA's?	No	Yes:_____

INJURY DETAILS / SYMPTOMS

Check those that apply:

Pain – aching / soreness	No	Yes:_____
Pain – shooting / stabbing	No	Yes:_____
Numbness / tingling	No	Yes:_____
Swelling / Edema	No	Yes:_____
Headaches	No	Yes:_____
Difficulty concentrating	No	Yes:_____
Confusion / memory loss	No	Yes:_____
Balance disturbances	No	Yes:_____
Trembling	No	Yes:_____
Jaw pain / clicking	No	Yes:_____
Throat irritation / clearing cough	No	Yes:_____
Difficulty swallowing	No	Yes:_____
Ringing in ears	No	Yes:_____
Vision disturbances	No	Yes:_____
Digestive problems	No	Yes:_____
Fatigue	No	Yes:_____
Weight loss / gain	No	Yes:_____

MEDICATION:

TYPE / DOSAGE / PURPOSE

_____
_____
_____
_____
_____
_____

I declare that I have read and understood this questionnaire and answered each question truthfully and correct to the best of my knowledge.

_____	_____	_____
CLIENT NAME (PRINT)	PARENT / GUARDIAN (PRINT)	KINESIOLOGIST (PRINT)
_____	_____	_____
SIGNATURE	SIGNATUE	SIGNATURE