Pre-Participation Screening Questionnaire

Name____ Date: ________________

Step 1: SYMPTOMS
Have you ever experience any of the signs and symptoms (listed below), at rest or during activity? (Check all that apply)

_____ Chest discomfort with exertion
_____ Unreasonable breathlessness
_____ Dizziness, fainting, or blackouts
_____ Ankle swelling
_____ Unpleasant awareness of a forceful, rapid or irregular heart beat
_____ Burning or cramping sensations in your lower legs when walking short distances

- If you did mark any of these statements under the symptoms, **STOP**, you should seek medical clearance before engaging in or resuming exercise. You may need to use a facility with medically qualified staff.
- If you **did not** mark any symptoms, continue to step 2 and 3

Step 2: CURRENT ACTIVITY
Are you currently performing planned, structured physical activity at least 30 min of moderate intensity on at least 3 days a week for at least the last 3 months?

_________YES
_________NO Comments: ____

- Continue to Step 3

Step 3: MEDICAL CONDITIONS
Do you currently have or ever had: (mark all that apply)

_____ A 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
_____ Diabetes Mellitus (Type I or II)
_____ Renal Disease

- If you **did not mark any of the Medical Conditions in Step 3**, medical clearance is not necessary.
- If you marked **'YES'** in **STEP 2** and marked any of the **Medical Conditions in Step 3** you may continue to exercise at light to moderate intensity without medical clearance. Medical Clearance is recommended before engaging in vigorous exercise
- If you marked **'NO'** in **STEP 2** and marked any of the **Medical Conditions in Step 3** medical clearance us recommended. You may need to use a facility with medically qualified staff.

Other health related issues:

_____ Musculoskeletal problems.____

_____ Concerns about the safety of exercise.____________________________________

_____ You take prescription medication(s). Please ID_____________________________

_____ You are pregnant. Due Date:____

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I (client),______________________________realize that the results of this screening may indicate that I may be at increased risk for health complications, including cardiovascular events or even death, during the pre-test, post-test procedures and when participating in the exercise program. It may be suggested to me that I see my physician for evaluation before I participate in the exercise program.

Signed (client): _____________________________________ Date: ______