Train Smart
Work Hard

Physical Activity Readiness Questionnaire

Please mark YES or No to the following:	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	____	____
Do you frequently have pains in your chest when you perform physical activity?	____	____
Have you had chest pain when you were not doing physical activity?	____	____
Do you lose your balance due to dizziness or do you ever lose consciousness?	____	____
Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?	____	____
Are you pregnant now or have you given birth within the last 6 months?	____	____
Have you had a recent surgery?	____	____

If you have marked YES to any of the above, please elaborate below:

_____

_____

Do you have any chronic illness or physical limitations such as Asthma, diabetes? Yes / No Please Specify

_____

Do you or have you had any injuries or orthopedic problems such as bursitis, bad knees, back, shoulder, wrist or neck issues? Yes / No Please specify _____

_____

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes / No

If yes, what is the medication for?_____

How does this medication affect your ability to exercise or achieve your fitness goals?

_____

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how much?_____

2) Do you drink alcohol? YES NO If yes, how many glasses per week?_____

3) How many hours do you regularly sleep at night? _____

4) Describe your job/lifestyle: ❍ Sedentary ❍ Active ❍ Physically Demanding

5) Does your job/lifestyle require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

7) List your 3 biggest sources of stress:

a. _____ b. _____ c._____

8) Is anyone in your family overweight? ❍Mother ❍Father ❍Sibling ❍Grandparent

9) Were you overweight as a child? YES NO If yes, at what age(s)?_____

Name: _____ Date: _____

Parent/guardian signature: _____ Date: _____

(if under 18 years of age)