



Date _____

Circle:

TEMP | SQUASH | SPT | TEAM BLDG

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

EXPIRES:

NAME _____ DATE OF BIRTH (mm/dd/yyyy) _____

ADDRESS _____ TOWN _____ ZIP CODE _____

EMAIL ADDRESS _____ CELL PHONE # _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ EMERGENCY CONTACT # _____

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE _____

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of any other reason why you should not engage in physical activity?		
8	Please list any known allergies:		

If you answered "Yes" to one or more of these questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

SIGNATURE (PARENT OR GUARDIAN IF UNDER 18) _____ DATE _____