BODYTRIO
BODY | MIND | SOUL

PAR Q FORM

Name: _____ Date: _____
Telephone: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____

In Case of Emergency Contact: _____ Relationship: _____
Address: _____ Phone: _____

Physician: _____ Specialty: _____
Address: _____ Phone: _____

Are you currently under a doctor's care?
☐ *Yes* ☐ *No*
If yes, explain: _____

When was the last time you had a physical examination?

Have you ever had an exercise stress test?
☐ *Yes* ☐ *No* ☐ *Don't Know*
If yes, were the results:
☐ *Normal* ☐ *Abnormal*

Do you take any medications on a regular basis?
☐ *Yes* ☐ *No*
If yes, please list medications and reasons for taking: _____

Have you been recently hospitalized?
☐ *Yes* ☐ *No*
If yes, explain: _____

Please tick the relevant box below as appropriate:

☐ *Yes* ☐ *No* Do you smoke?
☐ *Yes* ☐ *No* Are you pregnant?
☐ *Yes* ☐ *No* Do you drink alcohol more than 3x/week?
☐ *Yes* ☐ *No* Is your stress level high?
☐ *Yes* ☐ *No* Are you moderately active on most days of the week?

Do you have:
☐ *Yes* ☐ *No* High blood pressure?
☐ *Yes* ☐ *No* High cholesterol?
☐ *Yes* ☐ *No* Diabetes?

Have parents or siblings who, prior to age 55, had:
☐ *Yes* ☐ *No* A heart attack?
☐ *Yes* ☐ *No* A stroke?
☐ *Yes* ☐ *No* High blood pressure?
☐ *Yes* ☐ *No* High cholesterol?
☐ *Yes* ☐ *No* Known heart disease?
☐ *Yes* ☐ *No* Rheumatic heart disease?
☐ *Yes* ☐ *No* A heart murmur?
☐ *Yes* ☐ *No* Chest pain with exertion?
☐ *Yes* ☐ *No* Irregular heart beat or palpitations?
☐ *Yes* ☐ *No* Lightheadedness or do you faint?
☐ *Yes* ☐ *No* Unusual shortness of breath?
☐ *Yes* ☐ *No* Cramping pains in legs or feet?
☐ *Yes* ☐ *No* Emphysema?
☐ *Yes* ☐ *No* Other metabolic disorders (thyroid, kidney, etc.)?
☐ *Yes* ☐ *No* Epilepsy?
☐ *Yes* ☐ *No* Asthma?
☐ *Yes* ☐ *No* Back pain: upper, middle, lower?
☐ *Yes* ☐ *No* Other joint pain *(explain on back of form)*
☐ *Yes* ☐ *No* Muscle pain or an injury *(explain on back of form)*

To the best of my knowledge, the above information is true.

Signature: _____

Date: _____ Witness: _____