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:

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: ______