

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE



PATIENT'S NAME: _____ DOB: _____ DATE: _____

HEALTH CARE PROVIDER'S NAME: _____

Please read the questions below carefully, and answer each one honestly. Please check YES or NO.

- Yes No Has your health care provider ever said that you have a heart condition and that you should only do physical activity recommended by a health care provider?
- Yes No Do you feel pain in your chest when you do physical activity?
- Yes No In the past month, have you had chest pain when you were not doing physical activity?
- Yes No Do you lose your balance because of dizziness or do you ever lose consciousness?
- Yes No Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
- Yes No Is your health care provider currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- Yes No Do you know of any other reason why you should not do physical activity?

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