Luke McBroom, CPT

Confidentiality Agreement

Please Read The Below Statement And Sign Where Indicated.

I, _____ understand that the information collected by **Luke McBroom** will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Luke McBroom, CPT

Exercise History Questionnaire

Exercise History Information

Are you currently involved in a regular exercise program? ❒ Yes ❒ No

Do you regularly walk or run 1 or more miles continuously? ❒ Yes ❒ No

If yes, what is the average number of miles you cover in a workout? _____

What is your average time per mile? _____

Do you practice weightlifting or calisthenics? ❒ Yes ❒ No

Are you involved in an aerobic program? ❒ Yes ❒ No

If yes, what type(s)? _____

Do you frequently compete in competitive sports? ❒ Yes ❒ No

If yes which one(s)?

- ❒ Golf
- ❒ Bowling
- ❒ Tennis
- ❒ Handball
- ❒ Soccer
- ❒ Basketball
- ❒ Volleyball
- ❒ Football
- ❒ Baseball
- ❒ Track
- ❒ Other:_____
- ❒ Average number of times per week:_____

In which of the following high school or college athletics did you participate?

- ❒ None
- ❒ Football
- ❒ Basketball
- ❒ Baseball
- ❒ Soccer
- ❒ Other:_____
- ❒ Track
- ❒ Swimming
- ❒ Tennis
- ❒ Wrestling
- ❒ Golf

Do you frequently compete in competitive sports?

- ❒ Walking and/or Running
- ❒ Swimming
- ❒ Stationary Biking
- ❒ Jumping Rope
- ❒ Basketball
- ❒ Other:_____
- ❒ Bicycling (outdoors)
- ❒ Stationary Running
- ❒ Tennis
- ❒ Handball
- ❒ Squash

Comments:_____

_____

_____

_____

_____

_____

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS:_____
or GUARDIAN (for participants under the age of majority)

Luke McBroom, CPT

Health History Questionnaire

Answer Each Question By Printing The Necessary Information. Your Answers Are Confidential.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

Medical Information

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:	❒ Yes	❒ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking:	❒ Yes	❒ No
Please list any allergies:		
Has your doctor ever said your blood pressure was too high?	❒ Yes	❒ No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	❒ Yes	❒ No
Are you over the age of 65?	❒ Yes	❒ No
Are you unaccustomed to vigorous exercise?	❒ Yes	❒ No

Health History Questionnaire

Medical Information, continued

Is there any reason not mentioned why you should not follow a regular exercise program? ❒ Yes ❒ No
If yes, please explain:

Have you recently experienced any chest pain associated with either exercise or stress? ❒ Yes ❒ No
If yes, please explain:

Smoking

Please check the box that describes your current habits:

- ❒ Non-user or former user; Date quit:_____
- ❒ Cigar and/or pipe
- ❒ 15 or less cigarettes per day
- ❒ 16 to 25 cigarettes per day
- ❒ 26 to 35 cigarettes per day
- ❒ More than 35 cigarettes per day

Family and Personal Medical History

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- ❒ Asthma:_____
- ❒ Respiratory/Pulmonary Conditions:_____
- ❒ Diabetes: Type I:_____ Type II:_____ How Long?_____
- ❒ Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____
- ❒ Osteoporosis:_____

Lifestyle and Dietary Factors

Please fill in the information below:

- ❒ Occupational Stress Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Energy Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Caffeine Intake/Daily:_____ ❒ Alcohol Intake/Weekly:_____
- ❒ Colds Per Year:_____ ❒ Anemia:_____
- ❒ Gastrointestinal Disorder:_____
- ❒ Hypoglycemia:_____
- ❒ Thyroid Disorder:_____
- ❒ Pre/Postnatal:_____

Cardiovascular

Please fill in the information below:

- ❒ High Blood Pressure:_____ ❒ Hypertension:_____
- ❒ High Cholesterol:_____
- ❒ Hyperlipidemia:_____
- ❒ Heart Disease:_____
- ❒ Heart Disease:_____
- ❒ Heart Attack:_____ ❒ Stroke:_____
- ❒ Angina:_____ ❒ Gout:_____

Health History Questionnaire

Family and Personal Medical History, continued

Musculoskeletal Information

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- ❒ Head/Neck:_____
- ❒ Upper Back:_____
- ❒ Shoulder/Clavicle:_____
- ❒ Arm/Elbow:_____
- ❒ Wrist/Hand:_____
- ❒ Lower Back:_____
- ❒ Hip/Pelvis:_____
- ❒ Thigh/Knee:_____
- ❒ Arthritis:_____
- ❒ Hernia:_____
- ❒ Surgeries:_____
- ❒ Other:_____

Nutritional Information

Are you on any specific food/diet plan at this time? If yes, please list:	❒ Yes	❒ No
Do you take dietary supplements? If yes, please list:	❒ Yes	❒ No
Do you experience any frequent weight fluctuations?	❒ Yes	❒ No
Have you experienced a recent weight gain or loss? If yes, list change: Over how long?	❒ Yes	❒ No
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*		

Health History Questionnaire

Work And Exercise Habits

Please check the box that best describes your work and exercise Habits.

- ❒ Intense occupational and recreational exertion
- ❒ Moderate occupational and recreational exertion
- ❒ Sedentary occupational and intense recreational exertion
- ❒ Sedentary occupational and moderate recreational exertion
- ❒ Sedentary occupational and light recreational exertion
- ❒ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Home: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Do you work more than 40 hours a week? ❒ Yes ❒ No

Please make any other comments you feel are pertinent to your exercise program.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Luke McBroom, CPT

Informed Consent

Please Fill Out All Information Requested Below

I, (print name) _____ , give my consent to participate in the physical fitness evaluation program conducted by **Luke McBroom, CPT**.

BENEFITS

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

RISKS

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

TESTING AND EVALUATION RESULTS

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or bicycle ergometer test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide **Luke McBroom, CPT** with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at _____ , and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Luke McBroom, CPT

Medical History Questionnaire

PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW

Member's Name:			Date:		
Please indicate in the space provided if you have a history of the following:					
1.	Heart attack		YES		NO
2.	Bypass or cardiac surgery		YES		NO
3.	Chest discomfort with exertion		YES		NO
4.	High blood pressure		YES		NO
5.	Rapid or runaway heartbeat		YES		NO
6.	Skipped heartbeat		YES		NO
7.	Rheumatic fever		YES		NO
8.	Phlebitis or embolism		YES		NO
9.	Shortness of breath w/ or wo/exercise		YES		NO
10.	Fainting or light-headedness		YES		NO
11.	Pulmonary disease or disorder		YES		NO
12.	High blood fat (lipid) level		YES		NO
13.	Stroke		YES		NO
14.	Recent hospitalization for any cause		YES		NO
	List specifics:				
15.	Orthopedic problems (including arthritis)		YES		NO
	List specifics:				

FOR ANY OF THE CONDITIONS CHECKED ABOVE, PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:

Please note: possession of this form does not indicate certification status with the ISSA. To confirm active certification status, please call 1.800.892.4772 (1.805.745.8111 international). Information gathered from this form is not shared with ISSA. ISSA is not responsible or liable for the use or incorporation of the information contained in or collected from this form. Always consult your doctor concerning your health, diet, and physical activity.

Luke McBroom, CPT

Medical Release

Please complete the following information

It is my understanding that _____ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities. *(Please check all that apply.)*

1. Comprehensive physical fitness assessment including:
   - ❒ submaximal aerobic capacity test for cardiovascular endurance
   - ❒ resting heart rate, resting blood pressure
   - ❒ body composition analysis
   - ❒ flexibility
   - ❒ baseline upper and lower body strength measures
   - ❒ baseline upper and lower body endurance measures
   - ❒ other: _____
2. Exercise/rehabilitation program including:
   - ❒ resistance exercise program
   - ❒ cardiovascular exercise program
   - ❒ nutritional recommendations
   - ❒ other: _____

Please check the appropriate response:

- ❒ This patient may participate with no restrictions.
- ❒ This patient may participate with the following limitations:

- ❒ This patient may not participate. *(If checked, the individual will not be accepted.)*
- ❒ Other:

Diagnosis/Recommendations/Comments:

Signature

PHYSICIAN NAME *(please print)*

PHYSICIAN SIGNATURE DATE

PARTICIPANT NAME *(please print)*

PARTICIPANT SIGNATURE DATE

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it ***does not limit your current ability*** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	**YES** ☐ **NO** ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	**YES** ☐ **NO** ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	**YES** ☐ **NO** ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	**YES** ☐ **NO** ☐

3. Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm*

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	**YES** ☐ **NO** ☐
3c.	Do you have chronic heart failure?	**YES** ☐ **NO** ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	**YES** ☐ **NO** ☐

4. Do you have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	**YES** ☐ **NO** ☐

5. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	**YES** ☐ **NO** ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	**YES** ☐ **NO** ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	**YES** ☐ **NO** ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	**YES** ☐ **NO** ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	**YES** ☐ **NO** ☐

PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome*

If the above condition(s) is/are present, answer questions 6a-6b — If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d — If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c — If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c — If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c — If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com

Email: eparmedx@gmail.com

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

OSHF Ontario Society for Health and Fitness