

Physical Activity Readiness Questionnaire (PAR-Q)

Name: _____ Date: _____

A Questionnaire for People Aged 15 to 69

Regular physical activity is fun and healthy, and more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition <i>and</i> that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance because of dizziness, or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5. 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?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and to which questions you answered YES.

- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

If you answered NO to all of the questions

If you answered NO honestly to *all* PAR-Q questions, you can be reasonably sure that you can:

- Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

PLEASE NOTE:

If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

DELAY BECOMING MUCH MORE ACTIVE:

- If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- If you are or may be pregnant – talk to your doctor before you start becoming more active

PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL

YES NO

77. Back trouble/pain
 78. Neck trouble/pain
 79. Joint injury/pain/swelling
 80. Carpal tunnel syndrome

MISCELLANEOUS

YES NO

81. Bleeding/bruising easily
 82. Enlarged glands
 83. Rashes
 84. Unexplained lumps
 85. Chronic fatigue

YES NO

86. Night sweats
 87. Undesired weight loss
 88. Snoring
 89. Difficulty sleeping
 90. Low blood sugar

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES NO

91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page.
93. Have you had any surgical operations in the last 10 years?
94. Has anyone in your immediate family developed heart disease before the age of 60?
95. Do any diseases run in your family?
96. Do you currently have a cold/cough, or have you had any in the last two weeks?
97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page.
98. Are you currently under a doctor's care? If yes, list what you are being treated for on the next page.
100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?
102. Are you a current cigarette smoker?
 A. How many packs of cigarettes do you smoke a day? _____
 B. How long have you been smoking? _____
103. Are you an ex-smoker?
 A. How many years did you smoke? _____
 B. How many packs a day? _____
 C. When did you quit? _____
104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus _____ Flu shot _____ Pneumovax _____

107. When were you most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

109. Please describe typical weekly exercise or physical activities including any exercise at work:

110. My current diet could be best characterized as (check all that apply):

- Low-fat Low-carb High-protein Vegetarian/Vegan No special diet



Comprehensive Client Information Sheet

Name: _____

Date: _____

INSTRUCTIONS

This is your comprehensive client information sheet, in which we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. Please answer all questions in the most accurate manner possible while being as concise as possible.

DISCLAIMER

Please recognize the fact that it is your responsibility to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

COMPREHENSIVE CLIENT INFORMATION SHEET

PART 1: BASIC INFORMATION

Name _____ Gender _____ Age _____

Date of birth (month/day/year) _____ Height _____ Weight (as of this morning) _____

Body fat percentage (have this taken before submitting this sheet) _____

PART 2: BODY COMPOSITION

Please provide the following skinfold measures (in mm):

Please provide the following girth measurements (inches or centimetres).

Abdominal _____ Subscapular _____ Neck _____ Chest _____

Triceps _____ Suprailiac _____ Shoulder _____ Biceps _____

Chest _____ Thigh _____ Waist _____ Hips _____

Mid-axillary _____ Thigh _____ Calf _____

PART 3: GOALS

Given the following goals, please rank them in order of importance, with 1 being **most important** and 8 being **least important**.

Improved health _____ Improved endurance _____ Increased strength _____ Sport-specific* _____

Increased muscle mass _____ Fat loss _____ Increased power _____ Weight gain _____

*Please provide the sport or athletic event for which you are training:



COMPREHENSIVE CLIENT INFORMATION SHEET

Do you have a specific timeline for achieving a specific goal? If so, please specify:

Circle which type of progress is more important to you:

Immediate progress that's less easily maintained

Maintainable progress that may not be as rapid

Please explain below:

PART 4: EXERCISE INFORMATION

Rate your ability in the following exercises (check the box that corresponds with your ability):

EXERCISES:	ADVANCED	INTERMEDIATE	NOVICE	UNFAMILIAR
Barbell squats				
Barbell deadlift				
Barbell bench press				
Bent-over barbell row				
Barbell shoulder press				
Pull-up				
Barbell hack squat				
Olympic movements				
Snatch				
Clean				

Are you currently exercising regularly (at least 3x per week)?

Yes No

If you answered **YES**, continue on to the following section.

If you answered **NO**, skip ahead to the section marked "**Not currently exercising**".

Complete this section if you ARE currently exercising regularly

How long have you been consistently exercising without a break?

On the following chart, fill in which type of exercise you normally perform each day: resistance training (RT); interval cardio bouts (INT); low-intensity cardio bouts (LIC); sport-specific work (SSW).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Type of Exercise							



COMPREHENSIVE CLIENT INFORMATION SHEET

On the following chart, fill in your approximate workout duration for each day (in minutes).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Duration							

Please submit your current exercise regimen along with this form (type it up or write it out for us).

Complete this section if you ARE NOT currently exercising regularly

If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)?

Yes No

If you have exercised on a consistent basis previously, how long ago was this and how long did it last? _____

PART 5: MEDICAL AND HEALTH INFORMATION

If you have any diagnosed health problems, list the condition(s). _____

If you are on any medications, please list them. _____

What additional therapies or interventions are being undertaken for the given health problem(s)?

If you have any injuries, please list them. _____

What additional therapies or interventions are being undertaken for the given injury(s)?

PART 6: LIFESTYLE INFORMATION

What do you do for a living? _____

What is the activity level at your job?

None (seated work only) Moderate (light activity such as walking) High (heavy labor, very active)

Does your job involve shift work?

Yes No

If you follow a more regular schedule, do you work days, afternoons or nights? _____

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

Yes No

How often do you travel?

Rarely A few times a year A few times a month Weekly

Please list the physical activities that you participate in outside of the gym and outside of work.



COMPREHENSIVE CLIENT INFORMATION SHEET

If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

Please provide a three-day dietary record (attached). Be sure that these records are representative of the last few months of your dietary intake. In other words, if you just decided to get in shape two weeks ago and changed your diet dramatically, you should give us an indication of how you had been eating habitually prior to the recent change.

How long have you been eating in the manner recorded on your dietary record? (If your answer is less than one month, please fill out your record according to your prior intake before this recent month.)

MISCELLANEOUS INFORMATION

If there is any other information you think might be relevant to your program design, please share it with us below.

Please share your most frequent health, nutrition, or physique complaints and/or dissatisfactions with us.

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable) and three-day diet record, to your first appointment.



Readiness for Change Questionnaire

Name: _____ Date: _____

One of the most important things you can do to develop new daily practices is to understand your readiness for change. In addition, as your coach, it's useful for me to understand how willing you are to adopt some new practices, as slowly or as quickly as feels right for you.

Simply answer the questions below by selecting the response most appropriate to your situation. Together we'll calculate your score.

READINESS FOR CHANGE QUESTIONNAIRE

QUESTIONS:

RESPONSES AND SCORING

- | QUESTIONS: | RESPONSES AND SCORING |
|---|--|
| 1. Do you look in the mirror and feel frustrated, upset, or humiliated because of how your body looks? | a) Yes (+3)
b) I'm not sure (0)
c) No (-3) |
| 2. When you feel run down and tired, what do you think is the source of these feelings? | a) Getting older (-1)
b) My lifestyle choices (+3)
c) Something else altogether (-3) |
| 3. Are you taking any medications for heart disease, high blood pressure, or type II diabetes that you didn't have to take when you were younger? | a) Yes, I'm on two or more of these medications (+3)
b) Yes, I'm on only one of these medications (+1)
c) No, I'm not on any of these medications (-3) |
| 4. If your fitness has deteriorated over the years, how do you explain the fact that you're in worse shape than when you were younger but haven't changed your habits at all? | a) I think it's my family history (-1)
b) I think it's that I'm less active (+3)
c) I think it's a natural consequence of aging (-1)
d) I don't know why it's happening (0) |
| 5. If you don't have anyone to exercise with regularly, are you willing to look for a physical activity partner? | a) Yes (+5)
b) No (-5) |
| 6. Are you willing to join a gym today? | a) Yes (+3)
b) No (-3) |
| 7. If someone told you that you'd need to throw away all the foods in your cupboards today and go shopping for different foods that are more appropriate to your goal, would you do it? | a) Yes (+5)
b) No (-5) |
| 8. If an expert presents some information on diet and exercise that contradicts what you currently believe, what approach will you take? | a) Keep an open mind and give it a try (+3)
b) Ask a friend (0)
c) Ignore the advice (-3) |
| 9. Are you willing to have a meeting with your friends and loved ones and share your behavior goals and desired outcomes with them? | a) Yes, right away (+5)
b) Yes, but not just yet (-3)
c) No (-5) |



READINESS FOR CHANGE QUESTIONNAIRE

QUESTIONS:

RESPONSES AND SCORING

- | | |
|---|---|
| 10. If your work environment presents significant barriers to you exercising and eating well, would you consider speaking to your employer about changing some of these conditions or are you willing to find new employment? | a) Yes (+5)
b) No (-5) |
| 11. Are you ready to spend less time with people who offer little or no social support for your goals while spending more time with those who do offer support? | a) Yes (+5)
b) No (-5) |
| 12. Can you accept responsibility for the way your body is today and understand that, while your old habits don't make you a bad person, they still need to be changed? | a) Yes (+5)
b) No (-5) |
| 13. If a friend or loved one suggests that you don't have what it takes to get into great shape because you've failed before or for some other reason, what will be your response? | a) I can do it (+2)
b) I know I've got to make some changes but I'll take it one day at a time (+5)
c) Maybe I can't do it (-5) |
| 14. Are you willing to wake up in the morning a bit earlier and stay up at night a bit later to accomplish your goals? | a) Yes (+5)
b) No (-5) |
| 15. Are you willing to slowly work up to five hours of physical activity each week? | a) Yes (+5)
b) No (-5) |

YOUR SCORE AND WHAT IT MEANS

21 to 63:

It's clear that you're ready, willing, and able to adopt some new daily practices. Getting to this point is never easy. So congratulations. I look forward to helping you take that enthusiasm and turn it into results.

-20 to +20:

If you scored in this range, it seems like you're on the fence. You may be frustrated with the way things are but a little nervous about changing the way you do things today. Those feelings are totally normal and natural. I'm happy to help you move forward at the right pace for you.

-61 to -21:

From the results of your questionnaire, it seems like you're apprehensive about the change process. And that's totally okay. Most of my new clients experience the same thing, as this area can feel completely foreign to them. At this point, I'm happy to simply provide a healthy environment for you to consider adopting some new daily practices. They can be as small as you like; we'll go at your pace.



Kitchen Makeover Questionnaire

Name: _____ Date: _____

There's a fundamental law of human nutrition that goes like this:

If a food is in your possession or located in your residence, you will eventually eat it.

(Whether you plan to or not, whether you want to or not, you'll eventually eat it! Trust us.)
Therefore, according to this important law of human nutrition, if you wish to be healthy and lean, you must remove all foods that aren't part of your healthy eating program and replace them with a variety of better, healthier choices.

How do you know which foods have got to go and which foods can stay? Simply answer the questions below by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find out whether your kitchen is in good shape.

KITCHEN MAKEOVER QUESTIONNAIRE

QUESTIONS:

RESPONSES AND SCORING

1. Do you have the following items in your kitchen?

- * Good set of pots and pans
- * Good set of knives
- * Spatula
- * Blender
- * Tea kettle
- * Scale for weighing foods
- * Sealable containers for carrying meals
- * Small cooler for taking meals to work
- * Shaker bottle for drinks and shakes
- * Food processor

- a) I have all of them. (-5)
- b) I have more than half of them. (-2)
- c) I have less than half of them. (+2)
- d) I don't have any of them. (+5)

2. Do you have the following items in your pantry?

- * Whole oats
- * Quinoa
- * Whole-grain pasta
- * Natural peanut butter
- * Mixed nuts
- * Canned or bagged beans
- * Extra virgin olive oil
- * Vinegar
- * Green tea
- * Protein supplements
- * Fish oil/algae oil supplements
- * Green foods supplements

- a) I have all of them. (-5)
- b) I have more than half of them. (-2)
- c) I have less than half of them. (+2)
- d) I don't have any of them. (+5)

3. Do you have the following items in your fridge or freezer?

- * Extra-lean beef
- * Chicken breasts
- * Salmon
- * Omega-3 eggs
- * Packaged egg whites
- * Real cheese
- * At least four varieties of fruit
- * At least five varieties of vegetables
- * Flax seed oil
- * Water filter
- * Sweet potatoes
- * Tempeh

- a) I have all of them. (-5)
- b) I have more than half of them. (-2)
- c) I have less than half of them. (+2)
- d) I don't have any of them. (+5)

4. Do you have the following items in your pantry?

- * Potato or corn chips
- * Fruit or granola bars
- * Regular or low-fat cookies
- * Crackers
- * Instant foods like cake mixes and mashed potatoes
- * Bread crumbs, croutons, and other dried bread products
- * Chocolates or candy
- * Soft drinks
- * Regular peanut butter
- * At least four types of alcohol

- a) I have all of them. (+5)
- b) I have more than half of them. (+2)
- c) I have less than half of them. (-2)
- d) I don't have any of them. (-5)

KITCHEN MAKEOVER QUESTIONNAIRE

QUESTIONS:

RESPONSES AND SCORING

5. Do you have the following items in your fridge or freezer?
- | | | |
|---------------------------------|--|--|
| * At least four types of sauces | * Baked goods | a) I have all of them. (+5) |
| * Juicy steaks or sausage | * Frozen dinners | b) I have more than half of them. (+2) |
| * Margarine | * At least two types of bread or bagel | c) I have less than half of them. (-2) |
| * Fruit juice | * Take-out or restaurant leftovers | d) I don't have any of them. (-5) |
| * Soft drinks | * Big bowl of mashed potatoes or pasta | |
-
6. Do you have bowls of candy, chips, crackers, or other snacks sitting around at home?
- a) Yes (+5)
b) No (-5)
-
7. When you have parties or dinner guests, do you serve them what you think they'll want or what you think is healthy?
- a) What I think is healthy (-3)
b) What I think they want (+3)
-
8. When food shopping, do you buy economy-sized bags, or do you buy smaller portions?
- a) More than half of the time I buy economy-sized bags. (+3)
b) More than half of the time I buy smaller portions. (-3)
-
9. How often do you shop for groceries?
- a) Fewer than three times a month (+5)
b) About once a week (-1)
c) More than once a week (-5)
-
10. Do you keep food in plain view around the house?
- a) Yes (+3)
b) No (-3)
-
11. Do you think healthy eating means low-fat eating?
- a) Yes (+2)
b) No (-2)
-
12. If someone were to point to a food in your kitchen, would you know whether it was composed of mostly carbohydrate, protein, or fat?
- a) Yes (-2)
b) No (+2)
-
13. When you prepare meals from recipe books, do you use those that contain healthy recipes?
- a) Most of the time (-5)
b) About half of the time (0)
c) Almost never (+5)
-
14. Do you prepare meals in advance to take with you to work, on day trips, or on vacations?
- a) Yes, always (-5)
b) More than half the time (-2)
c) Less than half the time (+2)
d) Almost never (+5)
-
15. Are you hesitant to throw out unhealthy leftovers or gift foods that don't fit into your nutritional plan?
- a) Yes, I hate throwing food out (+5)
b) No, more than half the time I throw this stuff out (0)
c) No, I always throw this stuff out (-5)



KITCHEN MAKEOVER QUESTIONNAIRE

YOUR SCORE AND WHAT IT MEANS

32 to 63 points

You scored high on the kitchen makeover questionnaire. But this high score means you may need some adjustments to your kitchen set-up or your shopping habits. That's no problem, though. We'll be working on this together in the coming weeks.

0 to 31 points

Your kitchen environment could also use some improvements. I'll be happy to show you what to do and how to do it as we continue to work together.

-31 to -1 points

You're doing pretty well in the kitchen department. With just a few tweaks, it'll be easier than ever to improve your body composition, energy levels, and performance.

-32 to -63 points

Don't let negative scores fool you. In this questionnaire, negative scores mean a great kitchen environment. Nice work. In the coming week's I'll be happy to share even more strategies for keeping the great kitchen environment going.



Social Support Questionnaire

Name: _____ Date: _____

Social support is defined as having a network of people that support your endeavors, contribute positively to your decision-making processes, and are there for you when you need help. Scientists have suggested that people with this kind of network around them can transcend even the worst environments and accomplish great things. Unfortunately, people who don't have this type of network have a harder time accomplishing even modest goals. Remember this: who you are today and who you become in the future has a lot to do with whom you choose to spend your time.

The following questions are designed to assess your level of social support, which strongly influences how well you follow any nutrition or exercise program. Simply answer the questions below by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find the areas of your life that might present challenges to your progress.

A word of caution: once you recognize your challenges it's easy to blame them for your outcomes. Don't do this. Outside factors can affect you – if you let them. But you're in control. You have the power to place yourself in the right environment, so use it!

SOCIAL SUPPORT QUESTIONNAIRE

QUESTIONS:

RESPONSES AND SCORING

1. Do the people with whom you spend each day (at work or at home) follow healthy lifestyle habits such as exercising regularly, watching what they eat, and taking nutritional supplements?	a) Yes, most of them do. (+3) b) About half do and half don't. (0) c) No, most of them don't. (-3)
2. Does your spouse or partner follow healthy lifestyle habits such as exercising regularly, watching what s/he eats, and taking nutritional supplements?	a) Yes, my spouse/partner does. (+5) b) No, my spouse/partner doesn't. (-5) c) I don't have a spouse or partner. (0)
3. When you want to perform some physical activity such as going for a workout or taking a hike, is it easy for you to find a partner to go with you?	a) Yes, it's easy to find a partner. (+2) b) Yes, but very infrequently. (0) c) No, they never do. (-4)
4. At your workplace, do your coworkers regularly bring in treats like cookies, donuts, and other snacks?	a) Yes, they often do. (-4) b) Yes, but I typically don't indulge (0) c) No, they don't (+5)
5. If you go out to eat more than once per week, do the people you dine with order healthy selections?	a) Yes, they always do. (+2) b) Only about half of the time. (0) c) No, they never do. (-2)
6. Do you belong to any clubs, groups, or teams that meet at least twice per week and do some physical exercise (this does not include a health club membership)?	a) Yes, I've been a member for years. (+5) b) Yes, I've just started. (+2) c) No, I don't. (0)
7. Do you belong to a health club and attend, on average, at least three times per week?	a) Yes, I've been doing this for at least 1 year. (+2) b) Yes, I've just joined. (+1) c) No, I don't. (0)



SOCIAL SUPPORT QUESTIONNAIRE

QUESTIONS:

8. When discussing your nutrition and exercise goals with friends, do they seem interested in getting on board, or do they think you're crazy?

- a) They're very interested. (+2)
- b) They're not interested. (0)
- c) They think I'm crazy. (-2)

9. Do the people you live with bring home foods that aren't considered healthy or good for you?

- a) Always (-5)
- b) Sometimes (-3)
- c) Never (0)

10. Do the people you live with bring home foods that are considered healthy or good for you?

- a) Always (+5)
- b) Sometimes (0)
- c) Never (-5)

11. Do the people you live with or work with schedule activities for you that interfere with your pre-established exercise time?

- a) Always; they don't respect my time. (-3)
- b) Sometimes; they don't think about it. (-1)
- c) Never; they respect this time. (+3)

12. Do those around you bring nutrition, exercise, or supplement information to your attention so that you can stay informed about these topics?

- a) Always (+5)
- b) Sometimes (+2)
- c) Never (0)

YOUR SCORE AND WHAT IT MEANS

28 to 38 total points:

Congratulations, it looks like you've got a great social support network around you, a group of people that'll help support your desire to change some of your daily practices. Of course, that's not all you'll need to be successful. But it's a great start.

5 to 27 total points:

It looks like you've got some social support around you but there may be a few areas that will present challenges. Being aware of your social temptations, as indicated above, is a great place to begin. Together we can work on strategies for being successful in the face of those challenges

4 to -14 total points:

Your social support is lacking and may need a makeover. However, you're not alone here. Many people struggle with social support. And that's why our coaching together will provide some strategies for enhancing your support network.

-15 to -31 total points:

This score is quite low and may signal some definite challenges in your work and at-home environments, as well as in your relationships. These can often lead to old habits surfacing as many food related problems are really relationship and environment problems. However, this questionnaire will help us isolate the main challenges. And together we'll work on overcoming them.