

Physical Activity Readiness Questionnaire (PAR-Q) For the Pre/Post Natal Client

Name: _____ Today's Date: _____

D.O.B: _____ Due Date: _____

Address: _____

Tel No: _____ Occupation: _____

Partner's Name: _____

Address (if different from above): _____

Tel No. (if different from above): _____

Doctor: _____ Midwife: _____

Tel No: _____ Hospital: _____

Referred by: _____ No. of children: _____

Areas of Interest:

Nutrition Weight gain Exercise
 Breast feeding Changes during pregnancy

History

Previous exercise: _____

Have you experienced any of the following, past or present?

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hypoglycaemia	<input type="checkbox"/> Multiple births
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Pelvic/abdominal cramps	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Vaginal bleeding	<input type="checkbox"/> Knee problems or pain
<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back problems or pain
<input type="checkbox"/> Vaginal disorder	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Neck problems or pain
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Multiple gestation	

Is there anything in your medical history that you feel could effect your ability to exercise?

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Are you taking any medications? **Y or N**

Please list:

Is there anything about your pregnancy or birth you feel is relevant to your participation in an exercise programme:

What concerns you most about pregnancy, birth or the postnatal period?

What are your goals for participating in exercise?

For postnatal only

Date baby was born:

Type of delivery:

Did you have an episiotomy?

Are you breast-feeding?

Are you getting up at night ?

Are you napping during the day?

Signed:

Date:

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