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

Name: ………………………………………………

D.O.B. ………………………………………………

Due Date: ………………………...

Address: …………………………………………………………………………………………

……………………………………………………………………………………………………...

TelephoneNo. ………………………………….. **Occupation:** …………………………………...

Partner's Name: ………………………….............................

Address (If different from above): …………………………………………………………...

……………………………………………………………………………………………………...

Telephone No. (If different from above): ………………………………………….........................

Doctor & Surgery Address: ……………………………………………………….........................

……………………………………………………………….. **Telephone No.** ………………………...

Midwife: .... **Telephone No.** ………………………...

Hospital: ………………………………………………………………………….........................

Referred By: …………………………………………………………………………………...

No. of Children: ……………………………………………………………………….........................

Previous Exercise History: ……………………………………………………………….......

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Shortness of breath	**Y / N**	Heart Disease	**Y / N**	Diabetes	**Y / N**
Chest Pain	**Y / N**	Hypoglycaemia	**Y / N**	Multiple Births	**Y / N**
Miscarriage	**Y / N**	Cramps	**Y / N**	High Blood Pressure	**Y / N**
Eating Disorder	**Y / N**	Vaginal bleeding	**Y / N**	Knee problems/pain	**Y / N**
Seizures	**Y / N**	Arthritis	**Y / N**	Back problem/pain	**Y / N**
Vaginal Disorder	**Y / N**	Incompetent Cervix	**Y / N**	Neck problems/pain	**Y / N**
Blood Disorder	**Y / N**	Multiple Gestatiom	**Y / N**		**Y / N**

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

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Are you taking any medications? If yes, please list. ……………………………………………...

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

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What concerns you most about pregnancy, birth or the postnatal period?
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What are your goals for participating in exercise? ……………………………………….............................
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For Postnatal Only:

Date baby was born: ……………………………… **Type of Delivery:** ………………..............................
Did you have an episiotomy? ……………………... **Are you breast-feeding?** ……………......................
What are your sleep patterns: …………………………………………………………….............................
………...

Client's Name: …………………………………………………...

Client's Signature: …………………………………………………

Date: …………………………………………………...