**The Priority Care Center**
**A Program of the Humboldt IPA**

## Section 1—Demographic Information

| Primary Care Physician: | How were you referred: |
|---|---|

| Name (Last, First, M.I.): | A.K.A.: |
|---|---|

| Date of Birth: / / | Age: | Gender: Male Female Transgender Other |
|---|---|---|
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( ) |

| E-mail Address: | Do we have permission to contact you via e-mail? Yes No |
|---|---|
| Primary Spoken Language:<br>English<br>Spanish<br>Portuguese<br>Other: | To which racial or ethnic group(s) do you *most* identify:<br>African-American (non-Hispanic)<br>Asian/Pacific Islanders<br>Caucasian (non-Hispanic)<br>Latino or Hispanic<br>Native American or Aleut<br>Other: |
| Marital Status:<br>Single Partnered Married Separated Divorced Widowed | Full name of spouse or significant other: |

| Employer Name: | Employer Address: | Occupation: |
|---|---|---|
| Employment Status (choose all that apply):<br>Full-time Part-time Self-employed Not employed Retired Active Military | | Driver's License Number: |

## Section 2—Emergency Contact Information

| Contact Name: | Relation to Patient: |
|---|---|
| Address: | |

| Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( ) |
|---|---|---|

## **Section 3—Insurance Information:** if we have a copy of your Ins. card(s) skip this section

| **Primary Insurance**: | Subscriber ID Number: |
|---|---|
| Group Number: | Group Name: |

Complete the following questions if the subscriber is someone other than yourself, the patient.

| Subscriber's Name: | Subscriber's Date of Birth: / / | Relation to Patient: |
|---|---|---|

| Address: | Subscriber's SSN: |
|---|---|

| **Secondary Insurance**: | Subscriber ID Number: |
|---|---|
| Group Number: | Group Name: |

Complete the following questions if the subscriber is someone other than yourself, the patient.

| Subscriber's Name: | Subscriber's Date of Birth: / / | Relation to Patient: |
|---|---|---|

| Address: | Subscriber's SSN: |
|---|---|

| **Other Insurance:** | Subscriber ID Number: |
|---|---|

Complete the following questions if the subscriber is someone other than yourself, the patient.

| Group Number: | Group Name: |
|---|---|

| Subscriber's Name: | Subscriber's Date of Birth: / / | Relation to Patient: |
|---|---|---|

| Address: | Subscriber's SSN: |
|---|---|

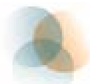
## Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to for The Priority Care Center to obtain my prescription history.

Signature_______________________________________________ Date__________/__________/__________



Name________________________ DOB ____________

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Name: ________________________________________ DOB: _______________ Gender: ☐M ☐F

Primary Care Provider: ____________________________________________________________

Preferred Pharmacy: ______________________________Location: ____________________

**CURRENT MEDICATIONS/SUPPLEMENTS** (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

| Name of Medication | Strength of Medication | Dosing Instructions |
|---|---|---|
| *Example: Tylenol* | *Example: 500 mg* | *Example: 1 pill three times a day* |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

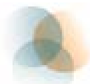
**Past Medical History** (Check all that apply)

| | | |
|---|---|---|
| ☐ Acid Reflux/GERD | ☐ Chronic Pain | ☐ High Blood Pressure |
| ☐ ADHD | ☐ Depression | ☐ High Cholesterol |
| ☐ Alcoholism | ☐ Diabetes | ☐ Irritable Bowel |
| ☐ Allergies | ☐ Emphysema/Bronchitis/COPD | ☐ Kidney Disease |
| ☐ Anemia | ☐ Epilepsy/Seizure Disorder | ☐ Liver Disease |
| ☐ Anxiety | ☐ Glaucoma/Cataracts | ☐Osteoporosis |
| ☐ Arthritis | ☐ Headaches | ☐ Stroke |
| ☐ Asthma | ☐ Hearing Loss | ☐ Thyroid Disease |
| ☐ Bleeding Disorders | ☐ Heart Disease | ☐ Other: ____________________ |
| ☐ Cancer | | |

**Allergies**

| ☐ No Known Allergies | ☐ Medication Allergies | ☐ Environmental/ Seasonal Allergies | ☐ Latex Allergy |
|---|---|---|---|

| List Allergies | Reaction |
|---|---|
| | |
| | |
| | |



Name________________________ DOB ____________

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## Past Surgical History

| Date of Surgery | Type of Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## Family Medical History

| Members | Status (Alive/Deceased) | Diabetes | High blood pressure | Heart Disease | Mental Illness | Cancer (Type) | High cholesterol | Unknown |
|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | |
| Mother | | | | | | | | |
| Paternal Grandfather | | | | | | | | |
| Paternal Grandmother | | | | | | | | |
| Maternal Grandfather | | | | | | | | |
| Maternal Grandmother | | | | | | | | |
| Siblings | | | | | | | | |
| Children | | | | | | | | |

## Social History

**Tobacco Use: Current use:** ☐Yes ☐No
**Past Use:** ☐Yes ☐No When did you quit? ____________________________
**Type:** ☐Cigarettes ☐Cigars ☐Chew ☐E-cigarette
**Recreational Drug Use:** ☐Yes ☐No
Type: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamine ☐Other______________________
**Alcohol Use**: ☐Daily ☐4-5 times per week ☐1-3 times per week ☐less than one time per week ☐none
**Type**: ☐Beer ☐Wine ☐Liquor
**Marital Status**: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
**Living Situation**: ☐Own ☐Rent ☐Homeless ☐Other ____________________________________________________
**Children**: ☐Yes ☐No if yes, do they live with you ☐Yes ☐No
**Support Network**: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other _________________
**Diet/Exercise: Are you on a special diet?** ☐Yes ☐No if yes, what type ________________________________
**Do you Exercise?** ☐Yes ☐No If yes, how often ☐Daily ☐3-5 days per week
☐1-2 days per week ☐less than once per week
What type ______________________________________________________________________________

Name_________________________ DOB _____________

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**Do you have an Advance Directive in place?**
☐Living Will ☐Durable Power of Attorney ☐Advanced Directive ☐POLST ☐None

**HEALTH MAINTENANCE**

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

| ***All Patients*** | | | |
|---|---|---|---|
| Last Tetanus Booster | ☐ Within past 10 years | ☐ More than 10 years ago | ☐ Unknown |
| Last Eye Exam (Dilated or Retinal) | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last Hearing Exam | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last Dental Exam | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last Foot Exam | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last colonoscopy/ sigmoidoscopy/Or stool test | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last DEXA Bone Scan | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last Pneumonia Vaccine | Date: __________ | | |
| Flu shot this season? | ☐ Yes ☐ No | | |
| ***Women Only*** | | | |
| Last Pap Smear | Date: __________ | ☐ Normal ☐ Abnormal | ☐ Unknown |
| Last Mammogram | Date: | ☐ Normal ☐ Abnormal | ☐ Unknown |

**Concerns**
Please indicate any concerns regarding your health in the space provided

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

v4;jrc3222016

NAME: ______________________________

Date: ______________________

| **PHQ-9** | | *Over the **last 2 weeks** how often have you been bothered by any of the following problems?* | *not at all* | *several days* | *more than half the days* | *nearly every day* |
|---|---|---|---|---|---|---|
| *1.* | Little interest or pleasure in doing things | | *0* | *1* | *2* | *3* |
| *2.* | Feeling down, depressed, or hopeless | | *0* | *1* | *2* | *3* |
| *3.* | Trouble falling or staying asleep, or sleeping too much | | *0* | *1* | *2* | *3* |
| *4.* | Feeling tired or having little energy | | *0* | *1* | *2* | *3* |
| *5.* | Poor appetite or overeating | | *0* | *1* | *2* | *3* |
| *6.* | Feeling bad about yourself — or that you are a failure or have let yourself or your family down | | *0* | *1* | *2* | *3* |
| *7.* | Trouble concentrating on things, such as reading the newspaper or watching television | | *0* | *1* | *2* | *3* |
| *8.* | Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | | *0* | *1* | *2* | *3* |
| *9.* | Thoughts that you would be better off dead or of hurting yourself in some way | | *0* | *1* | *2* | *3* |
| | *PHQ-9 total score =* | | | | | |

**Would you like someone from our office to contact you before your appointment regarding any of the above?**

____**Yes** _____**No**

**Are you currently undergoing any treatment for depression?**

☐ **Medications:** ______________________________

☐ **Counselor:** ______________________________

☐ **Other:** ______________________________

**Client Name:** ______________________________ **DOB:** ________ **Date obtained:** ________________

**(PROMIS) Patient Reported Outcomes Measurement Information System** is a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

# Global Health Assessment

**Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).**

| **Questions** | **Excellent (5)** | **Very Good (4)** | **Good (3)** | **Fair (2)** | **Poor (1)** |
|---|---|---|---|---|---|
| Global 01: In General, would you say your health is | | | | | |
| Global 02: In general, would you say your quality of life is | | | | | |
| Global 03: In general, how would you rate your physical health? | | | | | |
| Global 04: In general, how would you rate your mental health, including your mood and your ability to think? | | | | | |
| Global 05: In general, how would you rate your satisfaction with your social activities and relationships? | | | | | |
| Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc. | | | | | |
| | **Completely** | **Mostly** | **Moderately** | **A little** | **Not at all** |
| Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair? | | | | | |
| | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? | | | | | |
| | **None** | **Mild** | **Moderate** | **Severe** | **Very Severe** |
| Global 08: How would you rate your fatigue on Average? | | | | | |
| Global 07: How would you rate your pain on average? | ☐ 0 | ☐ 1 ☐ 2 ☐ 3 | ☐ 4 ☐ 5 ☐ 6 | ☐ 7 ☐ 8 ☐ 9 | ☐ 10 |
| To be completed by staff: Total Score (G03, 06, 07, 08)<br>Total Score (G02, 04, 05, 10) | | | | | ____________ |

Humboldt IPA

The Priority Care Center

**<u>Informed Consent for Participation in the Priority Care Center Wellness Program</u>**

NAME: ________________________________________Date of Birth _______________ DATE: ____________

**1. PURPOSE AND EXPLANATION OF PROCEDURE**

- I hereby consent to voluntarily engage in an acceptable plan of exercise and wellness coaching. I also give consent to be placed in personal fitness training program activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo exercise tests prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness.

- I will be given personal instructions regarding the amount and kind of exercise I should do. A professionally trained personal fitness trainer will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program.

- I have been informed that during my participation in the above described personal fitness training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the personal fitness training program personnel of my symptoms, should any develop.

- I understand that during the performance of exercise, a personal fitness trainer will periodically monitor my performance and, perhaps measuring my pulse, blood pressure, or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise program when any of these findings so indicate that this should be done for my safety and benefit.

- I also understand that during the performance of my personal fitness training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

**2. RISKS**

- It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the

risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as indicated.

**3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE**

- I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use of fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

**4. CONFIDENTIALITY AND USE OF INFORMATION**

- I have been informed that the information which is obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide facts which could lead to my identification. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

**5. INQUIRIES AND FREEDOM OF CONSENT**

- I have been given an opportunity to ask questions as to the procedures.

**6. Release of Liability for Participation in Wellness Program**

- I am voluntarily participating in the Wellness Program at the Priority Care Center. I recognize that the program requires physical exertion that may be strenuous at times and may cause physical injury and I am fully aware of the risks and hazards involved. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the above mentioned program. I have already so informed the program staff of all prescriptions, diagnoses, and symptoms and I further agree to so inform them promptly of any prescription, diagnosis, or symptom changes. I agree to assume full responsibility for any risks, injuries or damage know or unknown which I might incur as a result of participating in the program/classes. Such injuries may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, or any other illness or soreness, including death. I knowingly, voluntarily and expressly waive any claim I may have against the Priority Care Center Wellness Program or its employees for injury or damages that I may sustain as a result of participating in the program. I, my heirs or representatives forever release, waive, discharge and agree not to sue the Priority Care Center Wellness Program or its employees for any injury or death caused by their negligence or other acts. I have read the above waiver and release of liability and fully understand it contents. I voluntarily agree to the terms and conditions stated above.

**I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.**

**Participant's Signature**
______________________________________________________Date:_____________________
**Witness's Signature** _________________________________________________________ **Date:**
____________________

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

# PAR-Q & YOU

**(A Questionnaire for People Aged 15 to 69)**

Regular physical activity is fun and healthy, and increasingly 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 | | |
|---|---|---|---|
| ☐ | ☐ | 1. | **Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?** |
| ☐ | ☐ | 2. | **Do you feel pain in your chest when you do physical activity?** |
| ☐ | ☐ | 3. | **In the past month, have you had chest pain when you were not doing physical activity?** |
| ☐ | ☐ | 4. | **Do you lose your balance because of dizziness or do you ever lose consciousness?** |
| ☐ | ☐ | 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?** |
| ☐ | ☐ | 6. | **Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?** |
| ☐ | ☐ | 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 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 which 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.

## NO to all 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.

**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.

**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.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

**No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.**

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME ______________________________

SIGNATURE ______________________________ DATE ______________________________

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

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

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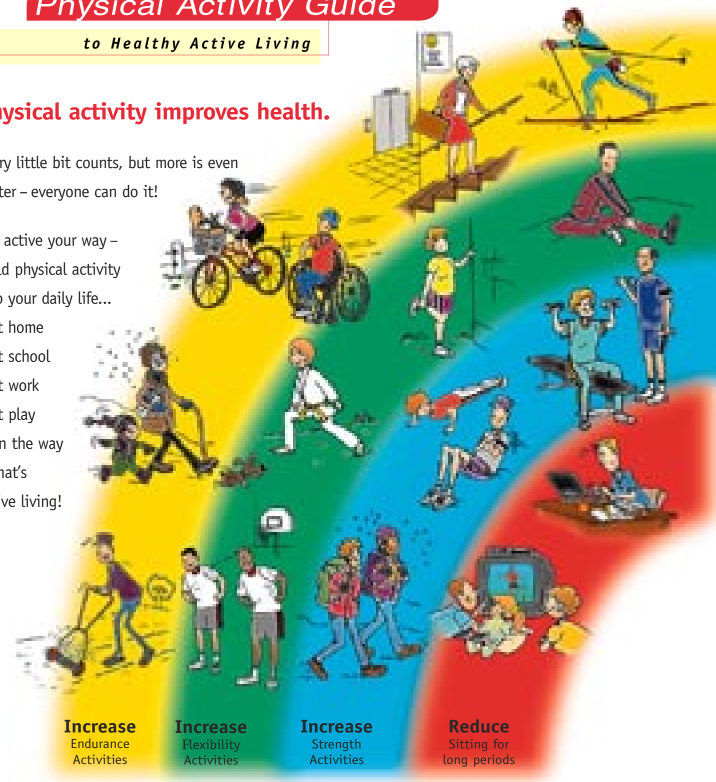
# PAR-Q & YOU

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

CANADA'S **Physical Activity Guide** to Healthy Active Living




## Physical activity improves health.

Every little bit counts, but more is even better – everyone can do it!

Get active your way – build physical activity into your daily life...

- at home
- at school
- at work
- at play
- on the way

...that's active living!

**Choose a variety of activities from these three groups:**

**Endurance**

4-7 days a week
Continuous activities for your heart, lungs and circulatory system.

**Flexibility**

4-7 days a week
Gentle reaching, bending and stretching activities to keep your muscles relaxed and joints mobile.

**Strength**

2-4 days a week
Activities against resistance to strengthen muscles and bones and improve posture.

Starting slowly is very safe for most people. Not sure? Consult your health professional.

For a copy of the *Guide Handbook* and more information: **1-888-334-9769**, or **www.paguide.com**

Eating well is also important. Follow *Canada's Food Guide to Healthy Eating* to make wise food choices.

## Get Active Your Way, Every Day – For Life!

Scientists say accumulate 60 minutes of physical activity every day to stay healthy or improve your health. As you progress to moderate activities you can cut down to 30 minutes, 4 days a week. Add-up your activities in periods of at least 10 minutes each. Start slowly… and build up.

**Time needed depends on effort**

| Very Light Effort | Light Effort *60 minutes* | Moderate Effort *30-60 minutes* | Vigorous Effort *20-30 minutes* | Maximum Effort |
|---|---|---|---|---|
| • Strolling<br>• Dusting | • Light walking<br>• Volleyball<br>• Easy gardening<br>• Stretching | • Brisk walking<br>• Biking<br>• Raking leaves<br>• Swimming<br>• Dancing<br>• Water aerobics | • Aerobics<br>• Jogging<br>• Hockey<br>• Basketball<br>• Fast swimming<br>• Fast dancing | • Sprinting<br>• Racing |

Range needed to stay healthy

**You Can Do It – Getting started is easier than you think**

Physical activity doesn t have to be very hard. Build physical activities into your daily routine.

- Walk whenever you can – get off the bus early, use the stairs instead of the elevator.
- Reduce inactivity for long periods, like watching TV.
- Get up from the couch and stretch and bend for a few minutes every hour.
- Play actively with your kids.
- Choose to walk, wheel or cycle for short trips.
- Start with a 10 minute walk – gradually increase the time.
- Find out about walking and cycling paths nearby and use them.
- Observe a physical activity class to see if you want to try it.
- Try one class to start – you don t have to make a long-term commitment.
- Do the activities you are doing now, more often.

| Benefits of regular activity: | Health risks of inactivity: |
|---|---|
| • better health<br>• improved fitness<br>• better posture and balance<br>• better self-esteem<br>• weight control<br>• stronger muscles and bones<br>• feeling more energetic<br>• relaxation and reduced stress<br>• continued independent living in later life | • premature death<br>• heart disease<br>• obesity<br>• high blood pressure<br>• adult-onset diabetes<br>• osteoporosis<br>• stroke<br>• depression<br>• colon cancer |

Health Canada / Santé Canada — Canadian Society for Exercise Physiology — ACTIVE LIVING

No changes permitted. Permission to photocopy this document in its entirety not required.
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Source: Canada's Physical Activity Guide to Healthy Active Living, Health Canada, 1998 http://www.hc-sc.gc.ca/hppb/paguide/pdf/guideEng.pdf

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**FITNESS AND HEALTH PROFESSIONALS MAY BE INTERESTED IN THE INFORMATION BELOW:**

The following companion forms are available for doctors' use by contacting the Canadian Society for Exercise Physiology (address below):

The **Physical Activity Readiness Medical Examination (PARmed-X)** – to be used by doctors with people who answer YES to one or more questions on the PAR-Q.

The **Physical Activity Readiness Medical Examination for Pregnancy (PARmed-X for Pregnancy)** – to be used by doctors with pregnant patients who wish to become more active.

References:

Arraix, G.A., Wigle, D.T., Mao, Y. (1992). Risk Assessment of Physical Activity and Physical Fitness in the Canada Health Survey Follow-Up Study. **J. Clin. Epidemiol.** 45:4 419-428.

Mottola, M., Wolfe, L.A. (1994). Active Living and Pregnancy, In: A. Quinney, L. Gauvin, T. Wall (eds.), **Toward Active Living: Proceedings of the International Conference on Physical Activity, Fitness and Health**. Champaign, IL: Human Kinetics.

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Thomas, S., Reading, J., Shephard, R.J. (1992). Revision of the Physical Activity Readiness Questionnaire (PAR-Q). **Can. J. Spt. Sci.** 17:4 338-345.

For more information, please contact the:

Canadian Society for Exercise Physiology
202-185 Somerset Street West
Ottawa, ON K2P 0J2
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