PHYSICAL Activity Readiness Questionnaire (PAR – Q) For the Pre/Post Natal Client

Name______________________________ 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?

☐ Shortness of breath	☐ Heart disease	☐ Diabetes
☐ Chest Pain	☐ Hypoglycaemia	☐ Multiple births
☐ Miscarriage	☐ Pelvic/abdominal cramps	☐ High blood pressure
☐ Eating disorder	☐ Vaginal bleeding	☐ Knee problems or pain
☐ Seizures	☐ Arthritis	☐ Back problems or pain
☐ Vaginal disorder	☐ Incompetent cervix	☐ Neck problems or pain
☐ Blood disorder	☐ Multiple gestation	

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

Are you taking any medications? Y or No

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?

Additional Note: I have taken medical advice and my doctor has agreed that I should exercise.

Clients Name:	Trainers Name:
Clients Signature:	Trainers Signature:
Date:	Date: