PAR-Q FORM **Please Mark YES OR NO to the Following:** **YES** **NO**

Has your doctor ever said that you have a heart condition and recommended _____ _____

Only medically supervised physical activity?

D o you frequently have pains in your chest when you perform physical activity? _____ _____

Have you had chest pain when you are not doing physical activity? _____ _____

Do you lose your balance due to dizziness or do you ever lose consciousness? _____ _____

Do you have a bone, joint or any other health problem that causes your pain or _____ _____

Limitations that must be addressed when developing an exercise program

(i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis

Anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?

Are you pregnant now or have given birth within the last 6 months? _____ _____

Have you had a recent surgery?

Do you take any medication, either prescription or non-prescription, on a _____ _____

regular basis?

Please check which of the following conditions you have had or now have and list any medications you are currently taking for that condition. Also check medical conditions in your family (father, mother, brother (s), or sister (s)). Check all that apply.

Medical Condition

Medication

Personal	Family		
€	€	Coronary heart disease, heart	
€	€	Angina	
€	€	High blood pressure ___mm Hg	
€	€	High cholesterol _____mg/dl	
€	€	Peripheral vascular disease	
€	€	Phlebitis or emboli	
€	€	Epilepsy	
€	€	Stroke	
€	€	Emphysema	
€	€	Pneumonia	
€	€	Asthma	
€	€	Bronchitis	
€	€	Diabetes (specify type:____)	
€	€	Thyroid conditions	
€	€	Osteoporosis	
€	€	Arthritis	
€	€	Anemia (low iron)	
€	€	Bone fracture	
€	€	Depression	
€	€	High anxiety, phobias	
€	€	Eating disorders (anorexia, bulimia)	
€	€	Sleeping problems	

How does this medication affect your ability to exercise or achieve your fitness goals?

_____I

If you have marked YES to any of the above, please elaborate below:

Lifestyle Related Questions:

1) Do you Smoke? YES NO If yes, how many? _____

2) Do you drink alcohol? YES NO If yes, how many glasses per week? _____

3) How many hour do you regularly sleep at night? _____

4) Describe your job Sedentary Active Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

7) List your 3 biggest sources of stress

a. _____ b. _____ c._____

8) Is anyone is your family overweight? _____

9) Were you overweight as a child? YES NO If yes, at what age (s)? _____

Fitness History:

1) When were you in the best shape of your life?_____

2) Have you been exercising consistently for the past 3 months? YES NO

3) When did you first start thinking about getting in shape? _____

4) What if anything stopped you in the past? _____

5) ON a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? _____

Nutrition Related Questions

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent) _____

2) How many times a day do you usually eat (including snacks)? _____

3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO

5) Do you eat late at night? Sometimes Often Never

6) What activities do you engage in while eating? (TV, reading, etc.) _____

7) How many glasses of water do you consume daily? _____

8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when? ___

9) Do you know how many calories you eat per day YES NO If yes, how many? _____

10) Are you currently or have you ever taken a multivitamin or any other good supplements? Y N

If yes, please list the supplements:

_____

_____

11) At work or school, do you usually: Eat out Bring food

12) How Many times per week do you eat out? _____

13) Do you do your own grocery shopping? YES NO

14) Do you do your own cooking? YES NO

15) Besides hunger, what other reason (s) do you eat?

Boredom Social Stressed Tired Depressed Happy Nervous

16) Do you eat past the point of fullness? Often Sometimes Never

17) Do you eat foods high in fat and sugar? Often Sometimes Never

18) List 3 areas of your Nutrition you would like to improve:

a. _____ b. _____ c. _____

Exercise Related Questions: Skip to the next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7 x/week 3-4 x/week 1-2 x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of interest Illness/Injury Lack of time Other _____

3) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Moderate/ Hard
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Strength Training	Frequency/Week	Average Length	Easy/Moderate/ Hard
	_____	_____	_____

List exercises: _____

_____

Stretching Frequency/Week Average Length

_____ _____

5) Please circle all the activities that interest you:

Aerobic Fitness Classes	Indoor Cycling	Snowshoeing
Baseball	Kayaking	Soccer
Boxing	Pilates	Swimming
Cross Country Skiing	Partner Training	Tennis
Football	Triathlon Private	Personal Training
Golf	Racquetball	Volleyball
Group Personal	Training Rock-climbing	Walking
Hiking	Running	Wally ball
Ice Skating	Skiing	White Water Rafting
Snowboarding	Yoga	

Developing your Fitness Program:

1. Please circle how you prefer to exercise:

a) INSIDE OUTSIE COMBINATION

B) LARGE GROUPS SMALL GROUPS ALONE COMBINATION

c) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise" _____ x/week

3. Realistically, how much time would you like to exercise? _____ x/week

4. What are the best days during the week for you to commit to your exercise program?

M T W TH F S S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Goal Setting:

How can we help you? Please circle that which applies.

Lose Body fat Develop Muscle Tone Rehabilitate an injury Nutrition Education

Start an Exercise program Design a more advanced program Safety

Sports Specific Training Increase Muscle Size Fun Motivation

Other: _____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART.'

S=Specific (Provide details, how long, how much etc.)

M=Measurable (How will you measure whether you've reached your goals)

A=Attainable (Be realistic, set smaller goals)

R=Rewards-Based (Attach a reward to each goal)

T=Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goal you would like to achieve in the ext 3-12 months?

a) _____

b) _____

c) _____

2. Where do you rate health in your life? Low Priory Medium Priority High Priority

3. How committed are you to achieving your fitness goals? Very Semi Not very

4. What do you think the most important thing we can do to help you achieve your fitness goals?

_____

_____

_____

_____

5. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc).

_____

_____

_____

6 Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

Miscellaneous Questions:

1. How did you hear about us? Please check that which applies.

Brochure Word or Mouth Flyer Newsletter Website

Health Professional (Doctor, Dietitian, Physical Therapist, etc) Meal Deliver Program WRS

Other_____

2. If you were referred to us, who told you about our services?

_____

3. Why did you choose to work with Alaric Health Beauty and Wellness instead of another organization?

Please check that which applies.

Location Personal Trainers Cost Customer Service Word of Mouth

Other_____

3. If you were referred to us, who told you about our services?

_____

4. How far do you live from our facility? _____ miles

5. Which newspaper (s) do you read? _____

6. Which magazine (s) do you read? _____

CLIENT HEALTH QUESTIONNAIRE

Please complete and return to Alaric Health Inc. at least 2 days prior to your

Scheduled consultation

All information received on this form will be treated as strictly confidential. Please fill out the forms ***completely and accurately***. This information is essential to helping us develop a program that addresses your needs, goals and interests and is safe and effective.

Please provide 24 hours notice if you need to cancel or reschedule your appointment.

Alaric Health Beauty and Wellness
Mailing Address: 4000 St. Johns Ave Suite 34-B Jacksonville, Fla. 32205
Phone: 904-384-9007 Fax: 904-384-9070
Alarichealth@comcast.net www.alarichealth.com

Name: _____ Date of Birth ___/___/___ Age: ____

Address: _____

Street City State Zip Code

Phone: _____ (h) _____ (0)_____ (fax)

Email address: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Physician's Name: _____ Physician's Phone: _____

Physician’s Address: ____

Street City State Zip Code