**CHAPTER 6 APPENDIX**

Form 6-1 PASQ Cover Letter

Form 6-2 PASQ – Professionally-Guided

Form 6-3 PASQ Interpretation Form

Form 6-4 PASQ Medical Clearance Form

Form 6-5 PASQ – Self-Guided

**Form 6-1: PASQ Cover Letter**

Dear Participant:

To increase the safety of our health/fitness programs and services as well as to comply with standards and/or guidelines established by major professional exercise/fitness organizations, we have all participants complete our Pre-Activity Health Screening process prior to participation. **Step 1** in this process is to complete the attached PASQ, our health history questionnaire that will take you about 4-5 minutes. The major purpose of obtaining this information is to help us identify individuals who may be at risk for an adverse event during exercise and who have any medical conditions that may require medical clearance prior to participation in health/fitness activities.

Once completed, it will be reviewed by one of our qualified staff members who will determine (using pre-established criteria) whether **Step 2** (obtaining medical clearance) is necessary prior to your participation in our programs and services. Obtaining clearance from your physician may be a slight inconvenience and may delay your participation, but it is an important step that can help ensure your safety while participating in our programs/services.

Medical Clearance

If necessary, you will receive our Medical Clearance Form. Attached to it will be a copy of your completed PASQ. Please take this form to your physician and ask him/her to complete and sign it. If you have recently seen your physician, he/she may complete and sign the form without seeing you for a medical evaluation. However, if is been a while (or for other reasons), your physician may want you to make an appointment for a medical evaluation. Regular medical evaluations are important for a variety of reasons such as having certain medical screenings/tests (e.g., cholesterol, blood pressure, cancer) that may detect an underlying health problem or disease. Early detection can save your life.

Privacy-Confidentiality-Security

All information obtained in our Pre-Activity Health Screening process will be kept private, confidential, and secure. At no time will any of this information be shared with any unauthorized individuals and it will be stored in a secure location.

Thank you for your participation in our Pre-Activity Health Screening process. We appreciate your understanding of this important process prior to participation in our health/fitness activities, which is to help improve your safety.

Sincerely,

The Management at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of health/fitness facility)

Copyright © 2020 by JoAnn M. Eickhoff-Shemek and Aaron C. Keese

**Form 6-2: PASQ – Professionally-Guided**

**Instructions:**

Please complete all four sections of this form. A staff member who is an exercise professional in our facility will review it and inform you if medical clearance is needed prior to engaging in physical activity.

**Section 1 -- Current Physical Activity**

When answering the questions in this section, please note the following definitions:

 Moderate Intensity: An activity that causes noticeable increases in heart rate and breathing (e.g., brisk walking)

 Vigorous Intensity: An activity that causes substantial increases in heart rate and breathing (e.g., jogging)

Over the last three months, have you regularly performed physical activity for at least 30 minutes, three days/week at a moderate intensity level?

**❑ No ❑ Yes**

**If yes,** which of the following best describes any vigorous intensity activity in your regular routine the last 3 months?

❑ I participate in some or all vigorous intensity activity

 ❑ None, but I want to begin some vigorous intensity activity

 ❑ None, and I want to continue moderate intensity activity

**Section 2 – Medical Conditions**

Please check the box (√) for any of the following medical conditions that you currently have or have had

❑ Heart attack

❑ Heart surgery

❑ Cardiac catheterization

❑ Coronary angioplasty (PTCA)

❑ Heart valve disease

❑ Heart failure

❑ Heart transplantation

❑ Congenital heart disease

❑ Abnormal heart rhythm

❑ Pacemaker/implantable cardiac defibrillator

❑ Peripheral vascular disease (PVD or PAD): disease affecting blood vessels in arms, hands, legs, and feet

❑ Cerebrovascular disease -- stroke or TIA (transient ischemic attack)

❑ Type 1 or Type 2 diabetes

❑ Renal (kidney) disease

**Section 3- Signs or Symptoms**

Please check the box (√) for any of the signs or symptoms that you have recently experienced**.**

❑ Pain, discomfort in the chest, neck, jaw or arms at rest or upon exertion

❑ Shortness of breath at rest or with mild exertion

❑ Dizziness or loss of consciousness during or shortly after exercise

❑ Shortness of breath occurring at rest or 2-5 hours after the onset of sleep

❑ Edema (swelling) in both ankles that is most evident at night or swelling in a limb

❑ An unpleasant awareness of forceful or rapid beating of the heart

❑ Pain in the legs or elsewhere while walking; often more severe when walking upstairs/uphill

❑ Known heart murmur

❑ Unusual fatigue or shortness of breath with usual activities

**Section 4- Acknowledgment, Follow-up, and Signature**

I acknowledge that I have read this questionnaire in its entirety and have responded accurately, completely, and to the best of my knowledge. Any questions regarding the items on this questionnaire were answered to my satisfaction. Also, if my health status changes at any time, I understand that I am responsible to inform a staff member at this facility of any such changes. I also understand that the PASQ is not a substitution for a medical examination.

Please note: The authors of the PASQ assume no liability for individuals who participate in physical activity and/or complete the PASQ. If questions arise after completing the PASQ, seek the advice of your healthcare provider prior to physical activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant’s Name - Please PrintParticipant’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Copyright © 2020 by JoAnn M. Eickhoff-Shemek and Aaron C. Keese

**Form 6-3: PASQ Interpretation Form**

**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Clearance Needed: ❑No ❑Yes**

**If yes,** Medical Clearance is needed for this participant for the following reason(s):

**❑** Inactive **and** checked at least one item in either Section 2 or Section 3

**❑** Active **and** checked at least one item in Section 2 **and** wants to begin vigorous intensity activity

**❑** Active **and** checked at least one item in Section 3

**Copy of PASQ and Medical Clearance form given to participant on:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date**

**Completed/signed Medical Clearance form received:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date**

**Reviewed and Interpreted by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name of Exercise Professional Date**

Copyright © 2020 by JoAnn M. Eickhoff-Shemek and Aaron C. Keese

**Form 6-4: PASQ Medical Clearance Form**

Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Participant) would like to participate in the exercise/fitness programs at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Facility Name), a **non-clinical health/fitness facility** that provides a variety of exercise/fitness activities. To comply with pre-activity screening recommendations established by the American College of Sports Medicine, we have all participants complete a brief health history questionnaire (PASQ). Based on the responses to the PASQ (copy attached), your patient needs to obtain medical clearance prior to participating in our exercise/fitness programs. Once completed and signed by you, your patient can return this clearance form to me or you can fax it to me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (secure fax number of fitness facility). If you have any questions, please feel free to contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (phone number and e-mail address of exercise professional responsible for processing screening procedures).

Thank you,

Name, credentials, and title of exercise professional staff member (e.g., John Smith, BS, ACSM EP-C, Fitness Director)

**Please check (√) one of the following:**

□ Not cleared to exercise at this facility – should be referred to a clinically supervised exercise program

□ Cleared to exercise at this facility

Please check (√) the highest exercise intensity level your patient is cleared for and provide any other restrictions/limitations

 □ Light (<57 to < 64% HR max)

 □ Moderate (64 to < 76% HR max)

 □ Vigorous (76 to < 96% HR max)

 □ Near Maximal to Maximal (> 96% HR max)

**Restrictions/Limitations:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Name (printed) Physician’s Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number Date**

Copyright © 2020 by JoAnn M. Eickhoff-Shemek and Aaron C. Keese

**Form 6-5: PASQ – Self-Guided**

**Instructions:**

Please complete this form and then refer to the Summary/Recommendations.

Please note: The authors of the PASQ assume no liability for individuals who participate in physical activity and/or complete the PASQ. If questions arise after completing the PASQ, seek the advice of your healthcare provider prior to physical activity. This PASQ is not a substitution for a medical examination.

**Current Physical Activity**

Over the last three months, have you regularly performed physical activity for at least 30 minutes, three days/week at a moderate intensity level?

 **Note:** Moderate intensity activity causes noticeable increases in heart rate and breathing

 such as walking at a brisk pace

**❑ Yes – Please proceed to page 2.**

**❑ No – Please complete the items below.**

**Section 1 – Medical Conditions**

Please check the box (√) for any of the following medical conditions that you have had or currently have.

❑ Heart attack

❑ Heart surgery

❑ Cardiac catheterization

❑ Coronary angioplasty (PTCA)

❑ Heart valve disease

❑ Heart failure

❑ Heart transplantation

❑ Congenital heart disease

❑ Abnormal heart rhythm

❑ Pacemaker/implantable cardiac defibrillator

❑ Peripheral vascular disease (PVD or PAD): disease affecting blood vessels in arms, hands, legs, and feet

❑ Cerebrovascular disease -- stroke or TIA (transient ischemic attack)

❑ Renal (kidney) disease

❑ Type 1 or Type 2 Diabetes

**Section 2 -- Signs or Symptoms**

Please check the box (√) for any of the signs/symptoms that you have recently experienced**.**

❑ Pain, discomfort in the chest, neck, jaw or arms at rest or upon exertion

❑ Shortness of breath at rest or with mild exertion

❑ Dizziness or loss of consciousness during or shortly after exercise

❑ Shortness of breath occurring at rest or 2-5 hours after the onset of sleep

❑ Edema (swelling) in both ankles that is most evident at night or swelling in a limb

❑ An unpleasant awareness of forceful or rapid beating of the heart

❑ Pain in the legs or elsewhere while walking; often more severe when walking upstairs/uphill

❑ Known heart murmur

❑ Unusual fatigue or shortness of breath with usual activities

**Summary/Recommendations:**

Did you check any of the items in Section 1 or in Section 2?

❑ Yes ❑ No

* Medical clearance**+** is recommended -- Medical clearance**+** is not necessary
* After obtaining medical clearance, begin with -- Begin with light**\*** to moderate**\*\*** intensity exercise light**\*** to moderate**\*\*** intensity exercise

and/or followrecommendations from healthcare provider

**+ Medical Clearance** -- approval from a healthcare professional to engage in physical activity

**\*Light Intensity** – an activity that causes slight increases in heart rate and breathing

**\*\*Moderate Intensity** -- an activity that causes noticeable increases in heart rate and breathing

**Physically Active Participants**

**Section 1 – Medical Conditions**

Please check the box (√) for any of the following medical conditions that you have had or currently have.

❑ Heart attack

❑ Heart surgery

❑ Coronary angioplasty (PTCA)

❑ Heart valve disease

❑ Heart failure

❑ Heart transplantation

❑ Congenital heart disease

❑ Abnormal heart rhythm

❑ Pacemaker/implantable cardiac defibrillator

❑ Peripheral vascular disease (PVD or PAD): disease affecting blood vessels in arms, hands, legs, and feet

❑ Cerebrovascular disease -- stroke or TIA (transient ischemic attack)

❑ Renal (liver) disease

❑ Type 1 or Type 2 diabetes

**Section 2- Signs or Symptoms**

Please check the box (√) for any of the signs/symptoms that you have recently experienced**.**

❑ Pain, discomfort in the chest, neck, jaw or arms at rest or upon exertion

❑ Shortness of breath at rest or with mild exertion

❑ Dizziness or loss of consciousness during or shortly after exercise

❑ Shortness of breath occurring at rest or 2-5 hours after the onset of sleep

❑ Edema (swelling) in both ankles that is most evident at night or swelling in a limb

❑ An unpleasant awareness of forceful or rapid beating of the heart

❑ Pain in the legs or elsewhere while walking; often more severe when walking upstairs/uphill

❑ Known heart murmur

❑ Unusual fatigue or shortness of breath with usual activities

**Summary/Recommendations:**

**1. Did you check any of the items in Section 1 or in Section 2?**

 **❑ No**

* Medical clearance**+** is not necessary
* Continue with moderate**\*** or vigorous**\*\*** intensity exercise

**2. Did you check any of the items in Section 1?**

 **❑ Yes**

* Medical clearance**+** is not necessary for continuing moderate**\*** intensity exercise
* Medical clearance**+** is recommended before engaging in vigorous**\*\*** intensity exercise

**3. Did you check any of the items in Section 2?**

 **❑ Yes**

* Discontinue physical activity and seek medical clearance**+**
* After obtaining medical clearance, may return to physical activity following recommendations from healthcare provider

**+ Medical Clearance** -- approval from a healthcare professional to engage in physical activity

**\*Moderate Intensity** -- an activity that causes noticeable increases in heart rate and breathing

**\*\*Vigorous Intensity** -- an activity that causes substantial increases in heart rate and breathing

Copyright © 2020 by JoAnn M. Eickhoff-Shemek and Aaron C. Keese