Physical Activity Readiness Questionnaire (PAR-Q)

Pre/Post-Natal

Name .....
Today's date .....
Date of birth .....
Due date .....
Occupation .....
Partner's name .....
Address .....
Home telephone .....
Work telephone .....
Email .....

Doctor's name .....
Telephone .....
Hospital .....
Midwife .....
No. of children .....
Referred by .....

Areas of Interest

Nutrition ☐	Weight gain ☐	Exercise ☐
Breast feeding ☐	Changes during pregnancy ☐	Other ☐

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 effect your ability to exercise?

Are you taking any medications? Yes ☐ No ☐
If yes, please list.

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? Yes ☐ No ☐

Are you breast-feeding? Yes ☐ No ☐

Are you getting up at night? Yes ☐ No ☐

Are you napping during the day? Yes ☐ No ☐

Signature .....

Print name .....

Date .....