



**SALEM STATE COLLEGE WELLNESS CENTER
PHYSICAL ACTIVITY READINESS QUESTIONNAIRE**

Please fill out BOTH sides of this form. Incomplete forms will not be accepted.

Name: _____ Age: _____ Sex: M _____ F _____
Last First

Do you have any heart problems such as coronary disease, angina or chest pain, irregular heartbeat, heart valve problems, or phlebitis? **YES NO**

Are you pregnant? **YES NO**

Are you diabetic? **YES NO**
 If yes: Type I _____ Type II _____

Do you have respiratory conditions such as emphysema or bronchitis? **YES NO**

Do you often feel dizzy, faint, or blackout? **YES NO**

Do you feel pain in your chest when you engage in physical activity? **YES NO**

Are you epileptic or do you experience seizures? **YES NO**

Do you have a joint or bone problem that could be made worse by a change in your physical activity? **YES NO**

Do you currently smoke cigarettes, cigars or pipes, or chew tobacco? **YES NO**

Are you a Male over 45 or a Female over 55 years of age? **YES NO**

Do you do less than 1 hour of activity per week? **YES NO**
 (including walking, housework, and other physical labor/exercise)

Heart attack/disease before 55 years of age in father or other male first-degree relative, or before 65 years of age in mother or other female first-degree relative? **YES NO**

Is your blood pressure equal to or greater than 140/90 (high blood pressure)? **YES NO**

Is your cholesterol level high? **YES NO**

Do you have any other medical condition(s), physical limitation(s), or health consideration(s) that might affect your safe participation in an exercise program? If yes, please elaborate:

Are you currently taking any medications or under a physician's care? If yes, please elaborate:

My signature below verifies that I have read, understood, and truthfully completed the above questionnaire. If my health condition changes so that my responses are no longer accurate, I agree to notify the SSC Wellness Center Staff immediately by documenting the changes and presenting them to a manager or supervisor. All information will be kept confidential.

Participant's Signature: _____ Date: _____

I have read and agree to abide by the Rules and Regulations: _____(initial)

Staff Use Only

- ___ Health history satisfactory for admittance to the SSC Wellness Center
- ___ Candidate needs to obtain medical clearance prior to admittance to the SSC Wellness Center

Receptionist's Name: _____ Exercise Technician's Name: _____
 Manager/Supervisor Signature: _____ Date: _____

Program Orientation Date: _____ Day: _____ Time: _____

