Foothills
Park & Recreation District

Senior Fitness Assessment
Participant Instructions

Date: _____
Time: _____

Although the physical risks associated with the testing are minimal, the following reminders are important in assuring your safety and optimal score.

- Avoid strenuous physical activity one or two days prior to assessment.
- Avoid excess alcohol or caffeine use for 24 hours prior to testing.
- Eat a light meal one hour prior to testing.
- Wear clothing and shoes appropriate for participating in physical activity.
- Bring reading glasses (if needed) for completing forms.
- Bring the completed Health History Questionnaire and Informed Consent form (and Medical Clearance forms, if required).
- Inform test administrator of any medical conditions or medications that could affect your performance.

Note: As part of your aerobic testing, you will be asked to perform the 2-minute step test to see how many times you can march in place for 2 minutes.

After you have determined that it is safe for you to participate in the tests, you should practice the step test at least once before the test day. This will help you determine the best pace for you on test day.

Please call Ann at 303-409-2264 with any questions or concerns.

HEALTH HISTORY QUESTIONNAIRE

You need **medical clearance** from your physician before participating in a Fitness Assessment if you:

- Answer yes to one or more questions on the Informed Consent form
- Have any conditions prohibitive to fitness testing or exercise

PERSONAL

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ E-mail_____

Date of Birth_____Sex_____ Weight_____ Height_____

MEDICAL HISTORY

PAST HISTORY

Check if you've had . . .

___heart murmur
___high blood pressure
___disease of arteries
___high cholesterol
___heart attack
___chest pain
___stroke
___cancer
___lung disease
___epilepsy
___diabetes mellitus
___operations
___varicose veins
___injuries to back, knees, ankles
___other

FAMILY HISTORY

Including parents, grand parents, siblings

___heart attacks
___high blood pressure
___heart operations
___congenital heart disease
___cancer
___diabetes mellitus
___other major illnesses

PRESENT SYMPTOMS

Do you experience . . .

___chest pains
___heart palpitations
___cancer
___shortness of breath
___back pain
___arthritis
___swollen legs
___injuries
___osteoporosis
___high blood pressure

Explain each item checked:_____
_____
_____
_____

PRESENT MEDICATIONS:_____
_____
_____
_____

In case of emergency, please contact:

Name_____ Phone _____

Signature_____

Foothills
Park & Recreation District

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

SECTION 1 - GENERAL HEALTH

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition **OR** high blood pressure?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6) Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer **NO** if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity. Go to Section 3 to sign the form. You do not need to complete Section 2.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Canada's Physical Activity Guidelines for your age (www.csep.ca/guidelines).
- You may take part in a health and fitness appraisal.
- If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP) or a CSEP Certified Personal Trainer® (CSEP-CPT).
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered YES to one or more of the questions above, please GO TO SECTION 2.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ before becoming more physically active OR
- Your health changes - please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity programme.

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SECTION 2 - CHRONIC MEDICAL CONDITIONS

1. Do you have Arthritis, Osteoporosis, or Back Problems?

YES ☐ If yes, answer questions 1a-1c **NO** ☐ If no, go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	**YES** ☐ **NO** ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	**YES** ☐ **NO** ☐

2. Do you have Cancer of any kind?

YES ☐ If yes, answer questions 2a-2b **NO** ☐ If no, go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	**YES** ☐ **NO** ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	**YES** ☐ **NO** ☐

3. Do you have Heart Disease or Cardiovascular Disease? *This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm*

YES ☐ If yes, answer questions 3a-3e **NO** ☐ If no, go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	**YES** ☐ **NO** ☐
3c.	Do you have chronic heart failure?	**YES** ☐ **NO** ☐
3d.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	**YES** ☐ **NO** ☐
3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	**YES** ☐ **NO** ☐

4. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*

YES ☐ If yes, answer questions 4a-4c **NO** ☐ If no, go to question 5

4a.	Is your blood sugar often above 13.0 mmol/L? (Answer **YES** if you are not sure)	**YES** ☐ **NO** ☐
4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	**YES** ☐ **NO** ☐
4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	**YES** ☐ **NO** ☐

5. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)*

YES ☐ If yes, answer questions 5a-5b **NO** ☐ If no, go to question 6

5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
5b.	Do you also have back problems affecting nerves or muscles?	**YES** ☐ **NO** ☐

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6. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

YES ☐ If yes, answer questions 6a-6d **NO** ☐ If no, go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
6c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

7. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

YES ☐ If yes, answer questions 7a-7c **NO** ☐ If no, go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

8. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

YES ☐ If yes, answer questions 8a-c **NO** ☐ If no, go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

9. Do you have any other medical condition not listed above or do you live with two chronic conditions?

YES ☐ If yes, answer questions 9a-c **NO** ☐ If no, read the advice on page 4

9a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
9c.	Do you currently live with two chronic conditions?	YES ☐ NO ☐

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

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If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active:

- It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP or CSEP-CPT) to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20-60 min of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal.
It is recommended strongly that you complete the specially designed online screening and exercise recommendations program (i.e., the ePARmed-X+; www.eparmedx.com) and/or visit a qualified exercise professional (CSEP-CEP) for further information.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ before becoming more physically active OR
- Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The PAR-Q+ Collaboration, the Canadian Society for Exercise Physiology, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.
- Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com or
Canadian Society for Exercise Physiology
www.csep.ca

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.

Key References
1. Jamnik VJ, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.

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Informed Consent/Assumption of Liability Form

You are being invited to participate in testing to evaluate your physical fitness. Your participation is entirely voluntary. If you agree to participate, you will be asked to perform a series of assessments designed to evaluate your upper-and lower-body strength, aerobic endurance, flexibility, agility, and balance. These assessments involve activities such as walking, standing, lifting, stepping, and stretching. The risk of engaging in these activities is similar to the risk of engaging in all moderate exercise and may possibly result in muscular fatigue and soreness, sprains and soft tissue injury, skeletal injury, dizziness, and fainting. There is also the risk of cardiac arrest, stroke, and even death.

If any of the following apply you should not participate in testing without written permission of your physician. Please contact Foothills Park & Recreation District for the Medical Clearance form (303)409-2264.

1. Your doctor has advised you not to exercise because of your medical condition(s).

2. You have experienced congestive heart failure.

3. You are currently experiencing joint pain, chest pain, dizziness, or have exertion-induced angina (chest tightness, pressure, pain, heaviness) during exercise.

4. You have uncontrolled high blood pressure (160/100 or above).

During the assessment you will be asked to perform within your physical "comfort zone" and never to push to a point of overexertion or beyond what you feel is safe. You will be instructed to notify the person monitoring your assessment if you feel any discomfort or experience any unusual physical symptoms such as unusual shortness of breath, dizziness, tightness or pain in the chest, irregular heartbeats, numbness, loss of balance, nausea, or blurred vision. If you are accidentally injured during testing, the test administrators will be unable to provide treatment for you other than basic first aid. You will be required to seek treatment from your own physician, which must be paid for by you or your insurance company.

You may discontinue participation in testing whenever you wish by asking to do so. By signing this form, you acknowledge the following:

1. I have read the full content of this document. I have been informed of the purpose of the testing and of the physical risks that I may encounter.

2. I agree to monitor my own physical condition during testing and agree to stop my participation and inform the person administering the assessment if I feel uncomfortable or experience any unusual symptoms.

3. I assume full responsibility for all risk of bodily injury and death as a result of participating in testing. Should I suffer an injury or become ill during testing, I understand that I must seek treatment from my own physician and that I or my insurance company will have to pay for this treatment.

My signature below indicates that I have had an opportunity to ask and have answered any questions I may have, and that I freely consent to participate in the physical assessment.

Signature _____ Date_____

Print Name_____