



**PHYSICAL Activity Readiness Questionnaire (PAR - Q)  
For the Pre/Post Natal Client**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Due Date: \_\_\_\_\_

Address: \_\_\_\_\_

Tel No: \_\_\_\_\_ Occupation: \_\_\_\_\_

Partner's Name: \_\_\_\_\_

Address: (If different from above) \_\_\_\_\_

Tel No: (If different from above) \_\_\_\_\_

Doctor: \_\_\_\_\_ Midwife: \_\_\_\_\_

Tel No: \_\_\_\_\_ Hospital: \_\_\_\_\_

Referred By: \_\_\_\_\_ No. of Children: \_\_\_\_\_

**Areas of interest:**

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> Nutrition      | <input type="checkbox"/> Weight Gain              | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Breast Feeding | <input type="checkbox"/> Changes During Pregnancy |                                   |

**History:**

Previous exercise: \_\_\_\_\_

Have you experienced any of the following, past or present?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Hypoglycaemia           | <input type="checkbox"/> Multiple Births       |
| <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Pelvic/Abdominal Cramps | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Vaginal Bleeding        | <input type="checkbox"/> Knee Problems or Pain |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Back Problems of Pain |
| <input type="checkbox"/> Vaginal Disorder    | <input type="checkbox"/> Incompetent Cervix      | <input type="checkbox"/> Neck Problems or Pain |
| <input type="checkbox"/> Blood Disorder      | <input type="checkbox"/> Multiple Gestation      |  |



Is there anything in your medical history that you feel could affect your ability to exercises?

\_\_\_\_\_

Are you taking any medications? Yes or No

\_\_\_\_\_

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? \_\_\_\_\_ Are you breast-feeding? \_\_\_\_\_

Are you getting up at night? \_\_\_\_\_ Are you napping during the day? \_\_\_\_\_

**Additional Note:** I have taken medical advice and my doctor has agreed that I should exercise.

**Clients Name:** \_\_\_\_\_

**Clients Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Trainers Name:** \_\_\_\_\_

**Trainers Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_