

J Force YOUTH - Data Sheet



Name: _____
Last First Middle

Date of Birth: _____ Age: _____
Month Day Year

Address: _____
Street City State Zip Code

Contact Number (best): _____ (Business/Home/Cell/Work)

Contact Number (alternative) _____ (Business/Home/Cell/Work)

Email: _____ Male Female

In case of emergency, please contact:

Name: _____ Relationship: _____

Address: _____

Phone: _____

Physical Activity Readiness Questionnaire (PAR-Q)

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with their physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly.

- Yes No Has a physician ever diagnosed you with a heart condition and recommended only medically supervised physical activity?
- Yes No When you perform physical activity, do you feel pain in your chest?
- Yes No Do you ever faint or get dizzy and lose your balance, or consciousness?
- Yes No Do you have a bone or joint problem that could be aggravated by physical activity?
- Yes No Do you have high blood pressure or a heart condition for which a physician is currently prescribing a medication?
- Yes No Are you pregnant or have you given birth within the last 6 months?
- Yes No Do you have insulin dependent diabetes, or do you have hypoglycemia?
- Yes No Do you suffer from exercise-induced asthma?
- Yes No Are you 65 years of age or older and not used to being very active?
- Yes No Have you had a recent surgery, and/or are you on any medication?
- Yes No Have you had a stroke?
- Yes No Are you aware, through your own experience or a doctor's advice, of any other physical reason against your exercising without medical supervision?
- Yes No Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?
- Yes No If you answered NO to the previous question, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?

If you answered yes to any of the above questions, talk with your doctor before you become more physically active. Tell your doctor your plan to exercise and to which questions you answered yes. If you honestly answered no to all questions you can be reasonably certain you can safely increase your level of physical activity gradually. If your health changes so you then answer yes to any of the above questions, seek guidance from a physician.

Participant's Signature: _____ Date: _____



Personal Medical History

Have you ever had (or currently have) any of the following? (please check all that apply)

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rapid Heart Beats at Rest | |
| <input type="checkbox"/> Skipped Heart Beats | <input type="checkbox"/> Extra Heart Beats | | |

If yes, please explain: _____

Are you currently taking any medication (depression/High BP)? Yes No

If yes, please list and explain: _____

Family History

Please put a check in front of any statements that apply to your family history.

- | | |
|---|--|
| <input type="checkbox"/> Parent died of heart attack prior to age 50 | <input type="checkbox"/> Parents, siblings with stroke |
| <input type="checkbox"/> Sibling died of heart attack prior to age 50 | <input type="checkbox"/> Parents, siblings with diabetes |
| <input type="checkbox"/> Parents, siblings with high blood pressure | <input type="checkbox"/> Other |

Please explain: _____

Muscular/Bone/Joint History

Have you ever had (or currently have) any of the following (please check all that apply)?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Back injury/problems | <input type="checkbox"/> Muscular pain/injuries |
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Hip problems | <input type="checkbox"/> Painful joints | <input type="checkbox"/> Tendonitis |

If yes, please explain: _____

Have you had surgery or been in a hospital for medical treatment? Yes No

If yes, please explain: _____

Are you under any type of medical observation or receiving treatment? Yes No

If yes, please explain: _____

INFORMED CONSENT

I hereby voluntarily give consent to engage in physical fitness. I understand there are certain changes which may occur during exercise. They include abnormal blood pressure, fainting, disorders of heart beat, and very rare instances of heart attack. I understand that every effort will be made to minimize problems during exercise.

I understand that I am responsible for monitoring my own condition when exercising, and should any unusual symptoms occur, I will cease my participation and inform the trainer of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty in breathing, and joint or muscle injury. Also, in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such exercise, and hereby release and hold harmless the Levine Jewish Community Center, and their agents and employees, from any and all health claims, suits, losses, or causes of action for damages, for injury or death, including claims for negligence, arising out of or related to my participation in physical fitness.

I have read the foregoing carefully and I understand its content. Any questions which may have occurred to me concerning this informed consent have been answered to my satisfaction.

Name: _____

Date: _____

Witness: _____

Date: _____