Grow to glow fitness

Physical Activity Readiness Questionnaire (PAR-Q) for Pregnancy

Name: _____ Address: _____

Phone No: _____

Email: _____ D.O.B. _____

Due Date/No. Of Weeks Pregnant: _____

Health Care Provider Details (HCP) - GP & Midwife: _____

Emergency Contact person and tel. number: _____

General PARQ:

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	Yes	No
2. Do you feel pain in your chest when you do physical activity?	Yes	No
3. In the past month, have you had chest pain when you were **not** doing physical activity?	Yes	No
4. Do you lose balance because of dizziness or do you ever lose consciousness?	Yes	No
5. Do you have a bone or joint problem (for example back, knee, hip) that could be made worse by a change in your physical activity?	Yes	No
6. Is your doctor currently prescribing medication for your blood pressure or heart condition?	Yes	No
7. Do you know of any other reason why you should not do physical activity?	Yes	No

Pregnancy Specific Screening (please circle):

Currently, or during previous pregnancies have you suffered any of the following conditions?
Please circle (and please note if only experienced in previous pregnancy).

Symphysis Pubis Dysfunction (SPD)	Sacrum or SIJ Pain	Carpal Tunnel Syndrome	Separation of your Abdominal Muscles
Bleeding during Pregnancy	Knee Pain	Low Back Pain	Varicose Veins
Upper Back Pain	Neck Pain	Coccyx Damage or Pain	Gestational Diabetes

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On the following questions, please provide as much detail as possible.

Last visit to Primary Health Provider and outcome? _____

_____

Scan results? _____

History of miscarriages? _____

How many times a day do you go to the toilet (including through the night)? Any leaks? _____

How has your sleep been throughout your pregnancy? _____

Briefly describe your current eating habits ? _____

_____

Is this your first / second / third / fourth / fifth baby? (please circle)

If you have older child(ren), how old are they, and what kind of birth(s) did you have?

_____

_____

Please circle Y or N to the following:

Any excessive or sudden swelling and water retention?	Yes	No
Any skin rashes, open or unhealed cuts or bruises?	Yes	No
Any history or blood clots or Thrombosis?	Yes	No
Any extreme calf pain, swelling or redness?	Yes	No
Any severe and chronic itching?	Yes	No
Extreme high blood pressure – current and previous history?	Yes	No
Any excessive thirst and urination?	Yes	No
Any rapid or large weight gain while Pregnant?	Yes	No
Any varicose veins or haemorrhoids?	Yes	No
Current multiple pregnancy (twins / triplets)?	Yes	No
Any constipation?	Yes	No

Disclaimer: "I have read, understood and accurately completed this questionnaire. I can confirm that I am voluntarily engaging in an acceptable level of exercise, and have sought the necessary clearance from my Health Care Professional".

SIGNATURE _____ TODAY'S DATE _____

PRINTED _____

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NOTE: Contraindications to Exercise

Listed below are the current guidelines on ABSOLUTE CONTRAINDICATIONS to exercise.
Please inform me immediately if you have experienced any of the following conditions (in this pregnancy) or have been told by your HCP that you have them.

Absolute Contradictions to Exercise During Pregnancy (Please circle any condition you are/have experienced)

1. Significant heart disease
2. Significant lung disease
3. Incompetent cervix
4. Multiple gestation at risk of premature labour
5. Persistent spotting/bleeding or Placenta Praevia
6. Premature labour
7. Ruptured membranes
8. Uncontrolled Type 1 Diabetes or Gestational Diabetes
9. Evidence of Intrauterine Growth Restriction
10. Pregnancy-induced Hypertension or Pre-Eclampsia
11. Uncontrolled epileptic fits / seizures

Please provide further information for any circled conditions

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